Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 17, 2025

Administrator
Lake Ridge Care Center Of Buffalo, Inc.
310 Lake Boulevard
Buffalo, MN 55313

RE: CCN: 245513
Cycle Start Date: December 6, 2024

Dear Administrator:

On December 23, 2024, we notified you a remedy was imposed. On January 15, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 7, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 7, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 23, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 7, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 7, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 17, 2025

Administrator
Lake Ridge Care Center Of Buffalo, Inc.
310 Lake Boulevard
Buffalo, MN 55313

Re: Reinspection Results
Event ID: 4T6X12

Dear Administrator:

On January 15, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 6, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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Electronically delivered
December 23, 2024

Administrator
Lake Ridge Care Center Of Buffalo, Inc.
310 Lake Boulevard
Buffalo, MN 55313

RE: CCN: 245513
Cycle Start Date: December 6, 2024

Dear Administrator:

On December 6, 2024, a survey was completed at your facility by the Minnesota Department(s) 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 7, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 7, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 7, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 7, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Lake Ridge Care Center Of Buffalo, Inc. will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 7, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Nikki Harvey, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nicole.Sassen@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division 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

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 6, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245513	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO, INC.	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
E 000	Initial Comments On 12/2/24 through 12/6/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On (12/2/24 through 12/6/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited:: H55131821C (MN00108585), H55131704C (MN0010582), H55131824C (MN00100816), and H55131822C (MN00108150), in addition the following complaint was reviewed: H55131823C (MN00108584) with a deficiency cited at F760. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

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

Electronically Signed | 12/31/2024

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

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a level II preadmission screening and resident review (PASARR) was completed for 1 of 1 residents (R35) residents reviewed with a diagnosis of Mild intellectual Disability. Findings include: R35's Annual Minimum Data Set (MDS), dated	F 644	Plan of Correction for Deficiency F644 It is the policy of Lake Ridge- Cassia to comply with the federal regulation requiring a Level II Preadmission Screening and Resident Review (PASARR) for residents with a diagnosis of Mild Intellectual Disability. To assure continued compliance, the following plan has been put into place:	12/31/24

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F 644	Continued From page 2 11/05/2024; indicated R35 had diagnosis of anxiety disorder. In review of R35's History and Physical, dated 10/27/23, diagnoses also included obsessive compulsive disorder (OCD) and Adjustment disorder with anxious mood. R35's admission date was 11/22/23. In review of R35' level I PASARR was completed on 10/30/23 prior to admission and indicated a PASARR level II was required before R35 admitted to a nursing facility. Form also indicated the presence of a developmental disability. In review of R35's Level II PASARR (dated 11/09/23) indicated the diagnosis of Mild Intellectual Disability. The anticipated length of stay: 61-90 days. In further review of R35's level II PASARR, under "Final Determination of Length of Stay", The screener completing this form marked the following: "The person has developmental disabilities or related conditions and meets one of the following conditions (if yes, pick one of next four options): > As determined by the physician, this person requires recuperative care for physical illness or surgery for the hospitalization was required within the past two weeks. This person does require nursing facility (NF) services and will be admitted to the NF for a time limited stay of 150 days or less. > This person has a terminal illness and/or requires hospice services. Based on signed statements from the physician, this person's life expectancy is six months or less. This person does require NF services and will be admitted to the NF for long-term care. > This person requires a NF stay of fewer than 30	F 644	Corrective Actions for Affected Resident Resident R35: A Level II PASARR has been completed for Resident R35 to ensure compliance with federal regulations. The results are documented in the resident's medical record and communicated to the interdisciplinary team. Identification of Other Potentially Affected Residents Review Process: Conduct a comprehensive review of all current residents with a diagnosis of Mild Intellectual Disability to ensure that a Level II PASARR has been completed and is maintained in a spreadsheet to track upcoming dates of compliance. Documentation Audit: Audit 100% of resident charts with similar diagnoses to identify any other instances of non-compliance. Measures to Prevent Recurrence Staff Training: Provided training to all admissions and social services staff on the requirements and procedures for completing Level II PASARRs prior to admissions. Facility Resident Services Director or LSW will document quarterly that discharge planning was offered and the outcome of that conversation will be documented. Interdisciplinary Team Meetings: Incorporate a review of PASARR status into regular interdisciplinary team meetings to ensure ongoing compliance.	

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F 644	Continued From page 3 days and the person is expected to return to the community following the brief NF stay. This person requires NF services and will be admitted to the NF. > This person had ongoing medical and health needs and requires NF services. This person will be admitted to the NF for a stay of 151 days or more." Of the four options given none of them were marked as the reason for admission. The Level II PASARR indicated "Anticipated Discharge Date" of 12/23/23. In further review of R35's medical record, a second Level I PASARR had been completed on 3/22/24. Both Level 1 PASARRs were accompanied by a Level II. Both Level IIs were dark and illegible, being unable to determine if R35 rquired any services, the nursing home could not provide. An attached email documented R35 had Department of Human Services (DHS) approval R35's continued long term care stay only through 11/20/2024. In interview on 12/04/24 at 10:16 a.m., R35 stated he had been living in a group home in Otsego before coming here. He was unaware of why he was in this facility, only that this was where he was to now live. During multiple survey observations, from 12/3/24 - 12/5/24, R35 was observed independently attending facility activities and meals with verbal cueing, laying on his bed watching TV, and walking around the central dayroom / entrance area people watching. On 12/04/24 at 3:25 p.m., attempt was made to	F 644	Monitoring and Auditing Audit Plan: The Resident Services Director or LSW will utilize a spreadsheet to earmark renewals in advance for OBRA Level II residents and retain written communications with all county agencies requesting renewal be processed. QAPI Review: Results of these audits will be reviewed by the facility's Quality Assurance and Performance Improvement (QAPI) committee. The committee will determine if further monitoring or audits are necessary based on audit findings. Responsible Person Compliance Maintenance: The Resident Services Director or LSW are responsible for maintaining compliance with the PASARR requirements and ensuring that corrective actions are implemented effectively. Completion Date Target Date: All corrective actions will be completed by January 7, 2025. By implementing this plan of correction, Lake Ridge- Cassia aims to ensure full compliance with federal regulations and improve the quality of care for all residents.	

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F 644	Continued From page 4 contact by phone the Wright County social worker (COLSW) who had completed all of R35's PASARRs. A voice message was left with a call back number. No call back had been received during the duration of the survey. During a telephone interview on 2/05/24 at 7:43 a.m., R35's family member (FAM)-A stated R35 had been in multiple group homes since his mother died. During the last group home stay, the facility was not monitoring R35's blood pressures and edema (fluid retention in his feet and legs), and had not been updating the primary physician when blood pressures were elevate and edema was present. Family requested nursing home stay due to their concerns the group home setting was not meeting R35's health care needs. FAM-A stated the biggest issue they group homes were having with R35, was resident digging in / playing with his bowel movements. The group home he was in was not monitoring his behavior, and R35 was storing stool soiled clothing throughout his room. Family had ask for oversight, but it was not being done by the facility. During interview on 12/04/24 at 3:11 p.m., licensed social workers (LSW)-A and LSW-B stated they were unaware R35's Level II PASARR had not been completed by the COLSW. Both LSWs stated they assumed the Level II PASARR was complete and accurate. LSW-B stated R35's family were concerned resident's health needs were not being met in the group home setting. Both LSWs state they are not the ones who determine R35's length of stay, but rather the COLSW and DHS. LSW-B stated the County has historically been behind in assessments. A review of the facility's policy, entitled	F 644		

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F 644	Continued From page 5 Pre-admission Screening and Resident Review (PASRR)-MN, last revised 3/18/24, the policy indicted the following: "Developmental Disability 1. Potential residents who are determined to have a developmental disability or related condition must be approved for admission by the state Developmental Disability Authority (DDA) and approval must include an approved length of stay prior to admission into the nursing facility."	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		12/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LAKE RIDGE CARE CENTER OF BUFFALO, INC.	310 LAKE BOULEVARD BUFFALO, MN 55313

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F 656	Continued From page 6 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed, accurate, and revised to assure assessed care needs were implemented for 1 of 2 residents (R35) reviewed for care planning. Findings include: R35's Annual Minimum Data Set (MDS), 11/05/2024; indicated R35 had diagnoses including anxiety disorder. In review of R35's History and Physical, dated 10/27/23, additional diagnoses included obsessive compulsive disorder (OCD) and Adjustment disorder with anxious mood.	F 656	Plan of Correction for Deficiency F656 It is the policy of Lake Ridge-Cassia to comply with the regulation that requires the development of a comprehensive, person-centered care plan that is accurate and revised to assure assessed care needs are implemented. _____ Plan of Correction To assure continued compliance, the following plan has been put into place: " Corrective Action for Affected Resident: o A comprehensive review and revision	

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F 656	Continued From page 7 In review of R35' level I PASARR was completed on 10/30/23 prior to admission and indicated a PASARR level II was required before R35 admitted to a nursing facility, indicated the presence of a developmental disability. In review of R35's Level II PASARR (dated 11/09/23) indicated the diagnosis of Mild Intellectual Disability. In review of R35's care plan (last revised 11/13/24), R35 had a documented problem of: "Problem Start Date: 11/22/2023 Category: Psychosocial Well-Being Resident has [PASARR] Level II for Persons with Mental Illness and or Intellectual Disability or a related condition due to DX of Obsessive-compulsive disorder, unspecified and Adjustment disorder with anxiety . Resident needs specialized services and the [PASARR] screening team has determined that resident meets the criteria for NF care. Wright County will provide or arrange for the following specialized mental health services. Goal: Resident will exhibit fewer mood symptoms of isolating self in the next 90 days and accept redirection and reassurance from staff and family. [Resident] will maintain active daily schedule per interests. Approaches: > Referral will be made to Senior Linkage Line for change of condition in accordance with MDS guidelines. > Referral will be made to Senior Linkage Line if resident has an inpatient psychiatric stay or equally intensive treatment.	F 656	of the care plan for Resident R35 has been conducted to ensure it accurately reflects the resident's assessed care needs. This will include input from the interdisciplinary team, the resident, and their family or representative. o The revised care plan will be implemented immediately, and staff will be informed of any changes to ensure proper execution of the care plan. " Actions to Identify Other Potential Residents: o A facility-wide audit will be conducted to identify any other residents who may have similar deficiencies in their care plans. This will involve reviewing the care plans of all residents to ensure they are comprehensive, person-centered, and accurately reflect assessed care needs. " Measures to Ensure Deficient Practice Does Not Recur: o Staff training sessions will be conducted to reinforce the importance of developing and maintaining comprehensive, person-centered care plans. This training will cover the process of care plan development, implementation, and revision. " Monitoring and Auditing: o The Resident Services Director or LSW have reviewed all care plans for residents with similar diagnosis to ensure compliance with the comprehensive, person-centered care plan requirements. o Results of these audits will be reviewed by the facility's Quality Assurance and Performance Improvement (QAPI) committee, which will decide if further monitoring or audits	

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F 656	Continued From page 8 > Resident will see their psychologist and psychiatrist on regular basis." In an interview on 12/6/24 at 8:40 a.m., LTC (long term care) clinical coordinator (LPN)-A stated the psycho-social care planning is completed by the social service department. LPN-A was unaware of any sessions with a psychologist or psychiatrist on regular basis. During an interview on 12/6/24 ay 8:49 a.m., the facility licensed social workers (LSW)-A and LSW-B stated the facility has arrangements with Associated Clinic or Psychology (ACP), however, R35 had never received services while in the facility. LSW-B stated in conversations with R35's family, they did not feel these services were necessary. LSW-B stated R35's Care plan should have been updated. In review of the facility's policy, entitled: Care Plan and Baseline Care Plan (last revised 10/14/22) indicted the following: "3. The interdisciplinary team, in conjunction with the resident, resident's family, significant other or resident representative, shall develop a comprehensive person-centered care plan for each resident. This comprehensive care plan will be in the [electronic health record] by day 21 of the stay or 7 days after completion of the comprehensive initial MDS, whichever comes first. 4. The resident care plan is constantly changing. It should be updated routinely in the electronic record to reflect resident's current condition. The resident care plan is reviewed for accuracy, updated with quarterly MDS review, and all other	F 656	are necessary. " Person Responsible for Maintaining Compliance: o The Director of Nursing is responsible for maintaining compliance with this plan of correction. " Completion Date: o The completion date for this plan of correction is set for January 7, 2025_____ _____ By implementing this plan of correction, Cassia aims to ensure that all residents receive care that is tailored to their individual needs and preferences, thereby enhancing their quality of life and well-being.	

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F 656	Continued From page 9 scheduled MDS assessments."	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and implement interventions to ensure proper wheelchair positioning and prevent potential complications for 2 of 2 residents (R6 and R19) reviewed for wheelchair usage. Findings include: R6's quarterly Minimum Data Set (MDS) dated 10/29/24, identified R6 had severe cognitive impairment. R6's care plan identified R6 had a self-care deficit and required assistance with transfers and occasionally with locomotion and utilized a wheelchair. During observation on 12/3/24 at 4:07 p.m., R6 was being pushed down hallway in her wheelchair with no foot pedal on. R6's left foot was dragging and bouncing on floor. Staff did not provide reminders to R6 to hold her foot up. During observation on 12/4/24 at 12:47 p.m., R6	F 684	Plan of Correction for Deficiency F684 _____ Policy Statement It is the policy of Lake Ridge-Cassia to comply with the regulation cited under F684, ensuring comprehensive assessment and implementation of interventions for proper wheelchair positioning to prevent potential complications for all residents. _____ Plan of Correction Corrective Actions for Affected Residents • Resident R6 and R19: o Facility has conducted a comprehensive reassessment of wheelchair pedal use for both residents. o Develop and implement individualized care plans with specific interventions to ensure proper wheelchair pedal usage has been done.	12/31/24

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F 684	Continued From page 10 was being pushed down hallway in her wheelchair with no foot pedal on. R6's left foot was dragging and bouncing on floor. Staff did not provide reminders to R6 to hold her foot up. During observation on 12/4/24 at 4:32 p.m., R6 was being pushed down hallway in her wheelchair with no foot pedal on. R6's left foot was dragging and bouncing on floor. Staff did not provide reminders to R6 to hold her foot up. During observation on 12/6/24 at 9:10 a.m., R6 was being pushed down hallway in her wheelchair with no foot pedal on. R6's left foot was dragging and bouncing on floor. Staff did not provide reminders to R6 to hold her foot up. R19's quarterly Minimum Data Set (MDS) dated 10/8/24, identified R19 had cognitive impairment. Further, R19's care plan identified R19 had a self-care deficit and required assistance with transfers and locomotion in a wheelchair to reach desired destinations and utilized a wheelchair. During observation on 12/2/24 at 11:36 a.m. R19 was being pushed down hallway in his wheelchair with no foot pedals on. R19's feet were dragging and bouncing on floor. Staff did not provide reminders to R19 to hold his feet up. During observation on 12/3/24 at 11:49 a.m. R19 was being pushed down hallway in his wheelchair with no foot pedals on. R19's feet were dragging and bouncing on floor. Staff did not provide reminders to R19 to hold his feet up. During observation on 12/3/24 at 4:52 p.m. R19 was being pushed down hallway in his wheelchair with no foot pedals on. R19's feet were dragging	F 684	o Educate staff on the importance of following care plans and care sheets at All Staff Meetings on December 17th and December 19th o Monitor residents for any signs of complications related to wheelchair pedal usage and adjust care plans as necessary. Identification of Other Potentially Affected Residents • Conducted a facility-wide audit to identify other residents using wheelchairs and assessed based on transfer status, mobility, self transferring, one sided deficits, fall susceptibility with pedal usage. • Reassess wheelchair pedal usage for all identified residents. • Implement necessary interventions and update care plans accordingly. Measures to Prevent Recurrence • Develop and implement a standardized protocol for assessing wheelchair pedal usage upon admission and during regular care plan reviews. • Establish a system for regular monitoring and documentation of wheelchair positioning for all residents using wheelchairs. Monitoring and Auditing • The Director of Nursing or Designee will perform hallway audits 3 times weekly for one month of wheelchair-using residents' specifically pedal usage to ensure compliance with proper wheelchair positioning and care plan interventions. • Results of these audits will be reviewed by the facility's QAPI committee, which will determine if further monitoring	

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F 684	Continued From page 11 and bouncing on floor. Staff did not provide reminders to R19 to hold his feet up. During observation on 12/4/24 at 4:39 p.m., foot pedal was observed laying on top of R19's walker along the wall in his room. During observation on 12/6/24 at 9:08 a.m. R19 was being pushed down hallway in his wheelchair with no foot pedals on. R19's feet were dragging and bouncing on floor. Staff did not provide reminders to R19 to hold his feet up. During interview on 12/4/24 at 3:25 p.m., nursing assistant (NA)-A stated foot pedals are used as needed. NA-A stated R6 has one foot pedal that should be used if staff are assisting her with propelling wheelchair. NA-A stated R19 has foot pedals that staff use as needed. During interview on 12/6/24 at 9:01 a.m., trained medication aide (TMA)-A stated foot pedals should be used for any resident who had them and needed staff assistance transporting to and from any destination. TMA-A stated R6 does not have or use foot pedals. TMA-A stated R19 does not use foot pedals often. During interview on 12/6/24 at 9:19 a.m., licensed practical nurse (LPN)-A stated foot pedals are used when the resident is not about to pick up their feet or needed assistant with keeping their feet off the floor. LPN-A stated foot pedals should be used for residents who are not able to keep their feet up when staff pushed the wheelchair to and from destinations. R6 did not use foot pedals. Foot pedals should be used for R19 if he was not picking his feet up. LPN-A stated she expected staff to utilize foot pedals in all observations noted	F 684	or audits are necessary. Responsible Person • The Director of Nursing is responsible for maintaining compliance with this plan of correction. Completion Date • The plan of correction will be fully implemented by January 7, 2025. _____ By implementing this plan of correction, Cassia aims to ensure the safety and well-being of all residents using wheelchairs, preventing potential complications and maintaining compliance with CMS regulations.	

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F 684	Continued From page 12 above. LPN-A stated it was important for foot pedals to be used for safety when escorting residents in a wheelchair to and from destinations and to prevent injuries. During interview on 12/6/24 at 9:48 a.m., director of nursing (DON) stated that foot pedals are assessed upon admission and would be accessible when needed. DON stated foot pedals are not always on the wheelchair but are stored in resident's room to be used as needed. When a resident was exhibiting signs of not being able to keep feet held off floor when being transported to and from destinations, DON expected foot pedals be placed on wheelchair and used. She expected staff to use foot pedals in all observations noted above. DON stated it was important to use foot pedals on wheelchair during transport to prevent injury and that it was best practice. A wheelchair positioning policy was requested but was not provided.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow a care planned intervention to prevent or reduce the risk of aspiration for 1 of	F 689	Plan of Correction for Deficiency F689 It is the policy of Lake Ridge-Cassia to	12/31/24

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F 689	Continued From page 13 2 residents (R7) reviewed for nutrition and needing supervision at meals. Findings include: R7's quarterly Minimum Data Set (MDS) dated 10/15/24, identified R7 had intact cognition and required assistance with all activities of daily living (ADL)'s. R7's diagnoses included traumatic brain dysfunction, unspecified intracranial injury with loss of consciousness of unspecified duration, hypertension, peripheral vascular disease, hemiplegia, traumatic brain injury, depression, polyneuropathy, dysphagia - oropharyngeal phase, dysarthria and anarthria, osteoarthritis, chronic kidney disease and bicipital tendinitis. MDS indicated R7 needed supervision or touching assistance with eating. R7's Nutrition Care Area Assessment (CAA) dated 7/23/24, identified R7 was at risk for swallowing problems due to dysphagia, need for special diet or altered consistency which might not appeal to resident and the inability to perform self-care or mobility without significant physical assistance. CAA indicated R7 was currently on a pureed diet with mildly (nectar) thick liquids, facility to continue to provide diet per order and observe weights and intakes for changes. No referrals at this time, will proceed to care plan with goal to tolerate food and fluids served. R7's care plan, print date of 12/4/24, identified R7 required a pureed diet (in smooth applesauce consistency) with mildly thick liquids (nectar) related to dysphagia with instructions to thicken liquids more if coughing. R7 utilized adaptive equipment to increase independence at meals (lipped plate and Kennedy cup). Staff was to	F 689	comply with the regulation that requires the facility to follow care planned interventions to prevent or reduce the risk of aspiration for residents needing supervision at meals. _____ Corrective Action for Affected Resident " Resident Affected: R7 " Action Taken: o Conducted a comprehensive review of R7's care plan to ensure all interventions to prevent aspiration are clearly documented and communicated to all staff. o Provided immediate re-education to all staff involved in R7's care on the importance of adhering to care planned interventions, specifically focusing on aspiration prevention strategies. o Implemented a monitoring system to ensure R7 receives appropriate supervision during meals, with documentation of compliance in R7's care records. R7 was positioned in the dining room to allow closer supervision and cueing. Long term care nurse coordinator has requested and received orders for OT and ST to evaluate the safest care plan for R7 but also allow him to remain as independent as possible in a safe manner. Identification of Other Potentially Affected Residents " Conducted a facility-wide audit to identify other residents who require supervision at meals and have care plans that include interventions to prevent aspiration.	

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F 689	Continued From page 14 provide close supervision at his table to control pacing and remind him to stop and swallow when he started coughing, resident's preference was to sit at a table by himself, resident used bedside table to eat in dining room. Care plan also identified R7 had an alteration in activities of daily living (ADLs) related to history of traumatic brain injury with subsequent hemiplegia/hemiparesis affecting right dominant side, weakness, osteoarthritis, polyneuropathy, and pain, at risk for decline in ADLs. An intervention directed staff to provide close supervision with all meals for pacing assist and to remind resident to place silverware down between bites and monitor bite size. R7's physician orders, print date of 12/4/24, included orders to assist resident with feeding to control bite size and diet of puree food in smooth/applesauce consistency with mildly/nectar thick liquids (if coughing, thicken more). Diet order included special instructions of close supervision to control pacing and remind him to stop and swallow when he started coughing. R7's quarterly nutrition review progress note, dated 10/14/24, indicated staff was to thicken liquids more if R7 was coughing and that R7 required close supervision when eating. Progress note also indicated R7 was to receive assistance at meal to control bite size/pacing and remind him to stop and swallow when starts coughing. During observation on 12/3/24 at 12:04 p.m., R7 was seated at table in dining room drinking chocolate milk out of Kennedy cup. At 12:08 p.m., R7 received a lipped plate and was using his left hand to eat with regular silverware. R7's food was	F 689	" Reviewed care plans and meal supervision practices for all residents identified in the audit to ensure compliance with care planned interventions. Measures to Ensure Non-Recurrence " All Nursing staff received updated training at All Staff meetings held on December 17th and December 19th on the importance of following care planned interventions, " Established a protocol for regular interdisciplinary team meetings to review and update care plans as needed, ensuring all staff are informed of any changes. Monitoring and Auditing " The Director of Nursing or Designee will audit the dining room by observation of residents with care plans that include meal supervision and aspiration prevention interventions on at least three times weekly basis for three months. " The Nurse in the Dining Room for Supervision or Designee C N A will enlist and assign other qualified staff to assist residents to meet care plan requirements. " Results of these audits will be reviewed by the facility's QAPI committee, which will determine if further monitoring or audits are necessary based on findings. Responsible Person " The Director of Nursing or Designee is responsible for maintaining compliance with this plan of correction. Completion Date " Completion Date: January 7, 2025	

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F 689	Continued From page 15 pureed and fluids were appropriately thickened. R7 was struggling to get food to his mouth due to not being able to flex left arm at the elbow. R7 took large spoonfuls of food and would take one spoonful after another without pacing between bites. At 12:26 p.m., R7 began coughing and had a non-productive cough that lasted several seconds. Staff did not intervene when R7 was coughing. No staff were present at his table and did not provide reminders to R7 throughout meal. Staff seated two tables away assisting another resident with eating. During observation on 12/3/24 at 5:08 p.m., R7 was seated at table in dining room and dietary staff delivered plate. R7's food was pureed and fluids were appropriately thickened. R7 was again struggling to get food to his mouth and had food dripping down face. Resident took large spoonfuls of food and would take one spoonful after another without pacing between bites. At 5:20 p.m., R7 continued sitting at table alone. At 5:36 p.m., R7 was assisted out of dining room by staff. No staff were present and did not provide reminders to R7 throughout meal. During observation on 12/4/24 at 12:08 p.m., R7 was sitting at table in dining room. R7's food was pureed and fluids were appropriately thickened. R7 was again struggling to get food to his mouth. At 12:16 p.m., R7 had food dripping down his face. At 12:17 p.m., R7 began coughing and had a non-productive cough. At 12:23 p.m., dietary staff went to R7's table, gathered dirty clothing protector and left table. At 12:24 p.m., staff asked R7 if he was finished, R7 nodded his head "yes". At 12:28 p.m., staff assisted R7 out of dining room. No staff were present and did not provide reminders to R7 throughout meal.	F 689	_____ This plan of correction is designed to address the identified deficiency and ensure ongoing compliance with regulatory requirements related to resident care and safety.	

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F 689	Continued From page 16 During interview on 12/4/24 at 3:27 p.m., nursing assistant (NA)-A stated R7 received pureed thickened foods due to difficulty swallowing. NA-A stated she was not aware of any other assistance R7 needed at mealtimes. During interview on 12/6/24 at 9:01 a.m., trained medication assistant (TMA)-A stated R7 was able to feed himself but needed close supervision which consisted of watching for coughing and monitoring bite size. TMA-A stated if R7 was taking too big of bites, staff were to provide reminders to R7 to slow down and watch bite size and staff may need to help with feeding as needed. During interview on 12/6/24 at 9:19 a.m., licensed practical nurse (LPN)-A stated R7 was independent with eating but needed supervision with ensuring he is not eating too much and providing reminders to take smaller bites and to slow down. LPN-A stated R7 did not need any assistance with eating but if staff heard any coughing they would go and check on his. LPN-A confirmed R7 had an order for close monitoring when eating. LPN-A stated it was important to ensure close supervision was occurring during mealtimes to ensure that R7 did not choke or aspirate on food. LPN-A stated staff should be providing reminders regarding bite size and to slow down when eating. During interview on 12/6/24 at 9:55 a.m., director of nursing (DON) stated R7 needed close supervision with meals as ordered and staff should be in close proximity to R7, so they are able to offer reminders as warranted. DON stated it was important to follow these	F 689		

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	245513	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO, INC.	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
F 689	Continued From page 17 orders/instructions as it was ordered for R7's safety and to work on R7 controlling his pace and reducing the risk for aspiration. The facility Feeding of residents by staff policy, dated 3/27/24, indicated residents unable to feed themselves will be provided with assistance per their care plan. Staff sit at eye level with resident and offer small bite-sized portions on the fork or spoon at a regular rate.	F 689		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to promptly obtain diuretic medication and failed to notify the physician to prevent the continued increase of carbon dioxide for 1 of 2 residents (R24) reviewed for medication errors. This practice resulted in a significant medication error and actual harm when R24 did not receive medication for 4 consecutive days resulting in R24 being sent to the emergency room to receive care for acute onset chronic respiratory failure with hypoxia (condition in which the body or a region of the body is deprived of adequate oxygen supply at the tissue level) and hypercapnia (condition where there is too much carbon dioxide (CO2) in the blood). Findings include: R24's quarterly Minimum Data Set (MDS) dated 9/10/24, identified R24 had severe cognitive	F 760	Plan of Correction for Deficiency F760 It is the policy of Lake Ridge- Cassia to comply with the federal regulation requiring that Residents are Free From Significant Medication Errors. To assure continued compliance, the following plan has been put into place: _____ Corrective Actions for Affected Resident • Resident R24: Prescription for Diamox was discontinued during R24 Hospitalization. _____ Identification of Other Potentially Affected Residents. At the Direction of the Facility Administrator, the Director of Nursing or Designee will run a report daily from the	12/31/24

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F 760	Continued From page 18 impairment and required assistance with all activities of daily living (ADL)'s. R24's diagnoses included acute on chronic diastolic heart failure, hypertension, hyponatremia, schizophrenia, chronic obstructive pulmonary disease, respiratory failure, acute and chronic respiratory failure with hypoxia, paroxysmal atrial fibrillation, acute kidney failure, dysphagia, and emphysema. R24's physician's order dated 10/25/2024, identified R24 was prescribed 250 milligrams (MG) of oral Diamox (diuretic medication) twice daily for increased CO2 and hypercapnia. Review of R24's laboratory results for labs drawn on 10/25/24, indicated R24's CO2 levels were greater than 45 mmol/L (millimoles per liter). The range for normal CO2 levels are between 20 to 29 mmol/L. Review of R24's medication administration record (MAR) from 10/21/24 to 11/3/24, identified Diamox was ordered on 10/25/24 but was not administered to R24 for a total of eight doses. Seven of the eight doses (10/25/24 through 10/28/24) indicated "Not Administered: Drug/Item Unavailable". Dose on 10/29/24 indicated "Not Administered: Drug/Item Unavailable - Comment: called A&E for supply". R24's progress notes from 10/25/24 to 10/29/24 gave no indication R24's Diamox prescription was never received from pharmacy or R24's provider was contacted. Progress notes failed to identify any attempt to receive or follow up on R24's Diamox medication. R24's progress note dated 10/29/24 at 11:04 a.m., indicated resident was sent to the	F 760	EMR system called Medications not Administered and will review and investigate any items not given. • Review Process: Director of Nursing or Designee conducted a review of the Medication Not Administered report. • Documentation Audit: Audit the EMR via Matrix report _____ Measures to Prevent Recurrence • Staff Training: Director of Nursing provided extensive small group training to all nursing personnel that administer medications including trained medication aides, LPNs and RNs educated that medication not given is a medication error. Changes to facility procedure consisted of proper communication chains, reminders of what to do when a medication is not available, training TMAs that they are not allowed to use the Drug unused /unavailable feature, communication to pharmacy and provider and placing progress notes on all communications that have transpired in progress notes. Director of Nursing provided education at all staff meetings on December 17th and December 19th. IDT members all assigned Relias training on Root Cause Analysis. • Interdisciplinary Team Meetings: Incorporate a review of medication errors into regular interdisciplinary team meetings. • Audit Plan: The Director of Nursing or Designee will run the Matrix report for Medications Not Administered for 3	

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F 760	Continued From page 19 emergency department (ER) due to difficulty breathing, severe low oxygen saturations (69%), high respirations (32 breaths per minute) and skin was gray in color. R24's hospital discharge summary dated 11/1/24, identified principal diagnoses of acute on chronic respiratory failure with hypoxia and hypercapnia. The following criteria for acute respiratory failure were met; increase of at least 2L (liters) from chronic home O2 (oxygen), PCO2 (partial pressure of arterial carbon dioxide) greater than 50, O2 sats less than 89% more than once, and respiratory rate greater than 20 breaths per minute. Summary indicated shortness of breath, at baseline resident on 3L oxygen and needed up to 15L of oxygen and now back down to 3L, although no wheezing patient had significantly diminished air entry to the bases, was retaining CO2 and likely leading to increased work of breathing and addition of oral prednisone (steroid) for 5 days. R24 was discharged from hospital and returned to facility on 11/1/24 at 1:30 p.m. During interview on 12/4/24 at 10:42 a.m., pharmacist stated Diamox was a lot like Lasix as it helped to rid body of excess fluid and worked by inhibiting the enzymes as it disrupted the balance between acid base ratios. Potential side effects of not receiving the medication would be shortness of breath. Pharmacist stated R24 not receiving eight doses of medication contributed to resident being sent to the ER for increased CO2 and hypercapnia. She would considered this a significant medication error as it would affect her breathing. Pharmacist stated medication was filled on 10/29/24 from the original prescription that was prescribed in April 2024 for once daily.	F 760	months. • QAPI Review: Results of these audits will be reviewed by the facility's Quality Assurance and Performance Improvement (QAPI) committee. The committee will determine if further monitoring or audits are necessary based on audit findings. _____ Responsible Person • Compliance Maintenance: The Director of Nursing or Designee are responsible for maintaining compliance with the safe administration of all medications for all residents and ensuring that corrective actions are implemented effectively. _____ Completion Date • Target Date: All corrective actions will be completed by January 7, 2025. _____ By implementing this plan of correction, Cassia aims to ensure full compliance with federal regulations and improve the quality of care for all residents.	

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F 760	Continued From page 20 She was not able to find an order, that was prescribed in October, for Diamox twice daily in the system. Pharmacist stated facility may not have sent the updated prescription to the pharmacy. During interview on 12/5/24 at 8:05 a.m., trained medication aide (TMA)-B stated if a medication was not available, she would notify the nurse. TMA-B stated the nurse does the communication/ordering of medications. TMA-B stated she would write down medications that are needed and give them to the nurse as "it is sometimes difficult to get things". TMA-B stated if it had been a couple of days and medication was still not available, she notified the nurse again to remind to call pharmacy to see where medication was. During interview on 12/5/24 at 9:01 a.m., nurse practitioner (NP) stated medication was prescribed on 10/25/24 on the direction of Dr. Dixon for increasing CO2 and hypercapnia based on labs that were obtained on 10/25/24. NP stated she was not aware of facility notifying her of resident not receiving medication. NP stated R24 was sent to the ER due to her history of COPD (chronic obstructive pulmonary disease) and CO2 retention. During interview on 12/5/24 at 10:20 a.m., TMA-C stated if medication was not available, she would first check the Omnicell to see if medication was available and if not, she would report it to the nurse by writing it on her report sheet. TMA-C stated the nurse was the only one that does the communication with pharmacy. TMA-C stated director of nursing (DON) talked to her on 12/3/24 regarding her process if medication was not	F 760		

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F 760	Continued From page 21 available. During interview on 12/5/24 at 10:46 a.m., health unit coordinator (HUC)-A and HUC-B stated when a new order was received, they enter the order in the electronic health record (EHR), place the order in file folder for nurse to review and scans the order to their email to send to pharmacy. HUC-A and HUC-B stated they did not have any confirmation page/email that order was sent to pharmacy. During interview on 12/5/24 at 10:58 a.m., licensed practical nurse (LPN)-B stated if a TMA was unable to find a medication, they should go and look in the Omnicell for medication. If medication was not available in the Omnicell, TMA should tell nurse who would call the pharmacy and document the communication in the progress notes. LPN-B stated new orders are entered in the EHR and sent to pharmacy by the HUC and then the nurse would go and verify the order. LPN-B stated she did not remember this medication or if she contacted pharmacy. LPN-B stated if she had contacted pharmacy, she would have documented it in a progress note. LPN-B stated she does not recall being updated by any TMA's that medication was not available. During interview on 12/5/24 at 11:39 a.m., TMA-D stated if medication was not available, she would check the Omnicell and would then notify the nurse. TMA-D stated the nurse was the one that follows up with pharmacy regarding medications. During interview on 12/5/24 at 12:29 p.m., LPN-C stated if medication was not available, Omnicell should be checked for availability. Pharmacy would then be called to check on the status and	F 760		

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F 760	Continued From page 22 would also check the medication receipt book from pharmacy to see if medication had been delivered. LPN-C stated a progress note would be documented regarding communication with the pharmacy. During interview on 12/5/24 at 12:39 p.m., DON stated she expected the nurse to contact pharmacy to get clarification on what was happening with delivery of any medication not received. She expected the TMAs to communicate to the nurse on duty when a medication was not available. Some nurses documented pharmacy communication in progress notes, and some documented it on the medication administration record (MAR). DON stated it was best practice to document all communication with providers. New orders were transcribed by the HUC and then placed in the unit folder for the nurse to verify order. DON stated the HUC sent orders to the pharmacy upon transcription of order. DON stated she was on medical leave at the time of medication error and that a preliminary investigation was completed by a LPN-A but was not thoroughly completed. From a clinical standpoint, there was a critical lab value, and we did not give the medication that was prescribed to mitigate the risk. If medication was administered as prescribed, they may not have needed to send R27 to the hospital. During interview on 12/6/24 at 9:19 a.m., LPN care coordinator-A stated if a medication was not available, the TMA would check the Omnicell to see if medication was available and if medication was not in Omnicell, TMA would notify the nurse. LPN-A stated the nurse would call the pharmacy to check on the status of the medication. LPN-A stated she would expect the nurse to document	F 760		

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F 760	Continued From page 23 any communication with pharmacy or providers. LPN-A stated she was notified on 10/29/24 that R24 had not received any Diamox that was prescribed on 10/25/24. She followed up with pharmacy, was informed the medication would be out for delivery on the night of 10/29/24. LPN-A stated she started the incident event in the EHR and mentioned the incident to a couple of people but did not do any other investigation and/or interviews regarding incident. During interview on 12/6/24 at 10:00 a.m., DON stated that she was in the middle of investigating the incident when she talked to surveyor on 12/5/24. DON identified if it wasn't charted, it wasn't done and confirmed no documentation was found regarding incident. DON stated education and new procedures were implemented in the past 12 hours to prevent reoccurrence. Changes to procedure consisted of proper communication chains, reminders of what to do when a medication was not available, changed the option in the EMR where TMAs are not able to use the "drug unused/unavailable" feature and education of placing a progress note on all communications that have transpired. During interview on 12/6/24 at 10:26 a.m., medical director stated the facility had not made him aware of this medication error and found it during his monthly review of incidents and pharmacy review. Medical director stated communication was not timely. The facility Medication Administration policy, dated 10/8/24, indicated medications will be administered by licensed nurses or trained medication aides under the supervision of a licensed nurse.	F 760		

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F 760	Continued From page 24 The facility Ordering Medication policy, dated 10/8/24, indicated if medication was not found, staff to look on the printed sheet to verify that it was filled and look for the medication before calling the pharmacy. If, after searching, staff cannot find the medication and it is not in the printout as being sent, call the pharmacy. The facility Trained Medication Aide job description, dated 12/8/2023, indicated TMAs are to report medication refused or not given to the overseeing nurse. The facility Licensed Practical Nurse job description, undated, indicated LPNs coordinated medications, supplies and equipment including ordering, receiving, storing, and disposing of all items in accordance with facility policies and procedures.	F 760		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 23, 2024

Administrator
Lake Ridge Care Center Of Buffalo, Inc.
310 Lake Boulevard
Buffalo, MN 55313

Re: State Nursing Home Licensing Orders
Event ID: 4T6X11

Dear Administrator:

The above facility was surveyed on December 2, 2024 through December 6, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Nikki Harvey, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nicole.Sassen@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00714	A. BUILDING: _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO, IN(	310 LAKE BOULEVARD BUFFALO, MN 55313

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/2/24 through 12/6/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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

Electronically Signed | 12/31/24

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H55131821C (MN00108585), H55131704C (MN0010582), H55131824C (MN00100816), and H55131822C (MN00108150) with NO licensing orders were issued, in addition H55131823C (MN00108584) was reviewed with licensing order issued at 1545. 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be	2 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 corrected prior to electronically submitting to the Minnesota Department of Health. 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed, accurate, and revised to assure assessed care needs were implemented for 1 of 2 residents (R35) reviewed for care planning. Findings include: R35's Annual Minimum Data Set (MDS), 11/05/2024; indicated R35 had diagnoses including anxiety disorder. In review of R35's History and Physical, dated 10/27/23, additional diagnoses included obsessive compulsive disorder (OCD) and Adjustment disorder with	2 565	Plan of Correction for Deficiency 0565 It is the policy of Lake Ridge-Cassia to comply with the regulation that requires the development of a comprehensive, person-centered care plan that is accurate and revised to assure assessed care needs are implemented. _____ Plan of Correction To assure continued compliance, the following plan has been put into place: " Corrective Action for Affected Resident:	12/31/24

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	00714	A. BUILDING: _____ B. WING _____	C 12/06/2024

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2 565	Continued From page 3 anxious mood. In review of R35' level I PASARR was completed on 10/30/23 prior to admission and indicated a PASARR level II was required before R35 admitted to a nursing facility, indicated the presence of a developmental disability. In review of R35's Level II PASARR (dated 11/09/23) indicated the diagnosis of Mild Intellectual Disability. In review of R35's care plan (last revised 11/13/24), R35 had a documented problem of: "Problem Start Date: 11/22/2023 Category: Psychosocial Well-Being Resident has [PASARR] Level II for Persons with Mental Illness and or Intellectual Disability or a related condition due to DX of Obsessive-compulsive disorder, unspecified and Adjustment disorder with anxiety . Resident needs specialized services and the [PASARR] screening team has determined that resident meets the criteria for NF care. Wright County will provide or arrange for the following specialized mental health services. Goal: Resident will exhibit fewer mood symptoms of isolating self in the next 90 days and accept redirection and reassurance from staff and family. [Resident] will maintain active daily schedule per interests. Approaches: > Referral will be made to Senior Linkage Line for change of condition in accordance with MDS guidelines. > Referral will be made to Senior Linkage Line if resident has an inpatient psychiatric stay or equally intensive treatment.	2 565	o A comprehensive review and revision of the care plan for Resident R35 has been conducted to ensure it accurately reflects the resident's assessed care needs. This will include input from the interdisciplinary team, the resident, and their family or representative. o The revised care plan will be implemented immediately, and staff will be informed of any changes to ensure proper execution of the care plan. " Actions to Identify Other Potential Residents: o A facility-wide audit will be conducted to identify any other residents who may have similar deficiencies in their care plans. This will involve reviewing the care plans of all residents to ensure they are comprehensive, person-centered, and accurately reflect assessed care needs. " Measures to Ensure Deficient Practice Does Not Recur: o Staff training sessions will be conducted to reinforce the importance of developing and maintaining comprehensive, person-centered care plans. This training will cover the process of care plan development, implementation, and revision. " Monitoring and Auditing: o The Resident Services Director or LSW have reviewed all care plans for residents with similar diagnosis to ensure compliance with the comprehensive, person-centered care plan requirements. o Results of these audits will be reviewed by the facility's Quality Assurance and Performance Improvement (QAPI) committee, which will decide if further monitoring or audits are necessary.	

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2 565	Continued From page 4 > Resident will see their psychologist and psychiatrist on regular basis." In an interview on 12/6/24 at 8:40 a.m., LTC (long term care) clinical coordinator (LPN)-A stated the psycho-social care planning is completed by the social service department. LPN-A was unaware of any sessions with a psychologist or psychiatrist on regular basis. During an interview on 12/6/24 ay 8:49 a.m., the facility licensed social workers (LSW)-A and LSW-B stated the facility has arrangements with Associated Clinic or Psychology (ACP), however, R35 had never received services while in the facility. LSW-B stated in conversations with R35's family, they did not feel these services were necessary. LSW-B stated R35's Care plan should have been updated. In review of the facility's policy, entitled: Care Plan and Baseline Care Plan (last revised 10/14/22) indicted the following: "3. The interdisciplinary team, in conjunction with the resident, resident's family, significant other or resident representative, shall develop a comprehensive person-centered care plan for each resident. This comprehensive care plan will be in the [electronic health record] by day 21 of the stay or 7 days after completion of the comprehensive initial MDS, whichever comes first. 4. The resident care plan is constantly changing. It should be updated routinely in the electronic record to reflect resident's current condition. The resident care plan is reviewed for accuracy, updated with quarterly MDS review, and all other scheduled MDS assessments."	2 565	" Person Responsible for Maintaining Compliance: o The Director of Nursing is responsible for maintaining compliance with this plan of correction. " Completion Date: o The completion date for this plan of correction is set for January 7, 2025_____ _____ By implementing this plan of correction, Cassia aims to ensure that all residents receive care that is tailored to their individual needs and preferences, thereby enhancing their quality of life and well-being.	

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2 565	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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	245513	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/05/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/05/2024. At the time of this survey, Lake Ridge Care Center Of Buffalo was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/27/2024

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

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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 1962 and was determined to be of Type II(111) construction. In 1974, an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the addition meet the construction type	K 000		

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K 000	Continued From page 2 allowed for existing buildings, the facility was surveyed as one building. The 3rd addition was constructed in 2014, is one-story, is fully fire sprinkler protected and is of Type II(111) construction. The facility has a capacity of 56 beds and had a census of 46 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K 920		12/26/24

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K 920	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 12/05/2024 at 10:36 AM, it was revealed by observation that medical equipment was plugged into a non-hospital grade power strip in resident room 119W. An interview with the Environmental Services Director verfied this deficient finding at the time of discovery.	K 920	Please find POC for Tag K920 Electrical Equipment Power Cords and Extensions 1.A detailed description of the corrective action taken or planned to correct the deficiency. The device in 119 was removed from the improper strip promptly and was plugged into a proper medical grade device. An entire house wide audit was performed the same day of the survey and any similar infractions were remedied 2.Address the measures that will be put in place to ensure the deficiency does not reoccur. We educated all staff on December 17th and December 19th at our All Staff Meetings about the various types of devices and the importance of how to utilize the correct device for medical equipment. 3.Indicate how the facility plans to monitor future performance to ensure solutions are sustained The Maintenance Director or his designee will do weekly audits for 4 weeks with education being provided in the moment and then after those 4 cycles of weekly audits we will perform monthly audits 4.Identify who is responsible for the corrective actions and monitoring of compliance. The Maintenance Director or his Designee 5.The actual or proposed date for completion of the remedy. 1/26/2025	