DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 16, 2021

Administrator
Buffalo Lake Health Care Ctr
703 West Yellowstone Trail, Po 368
Buffalo Lake, MN 55314

RE: CCN: 245589
Cycle Start Date: December 22, 2020

Dear Administrator:

On January 11, 2021, we notified you a remedy was imposed. On March 9, 2021 the Minnesota Department(s) of Health 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 February 19, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 25, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 11, 2021, 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 February 25, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 19, 2021, 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 Therefore, the NATCEP prohibition is rescinded.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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
January 11, 2021

Administrator
Buffalo Lake Health Care Ctr
703 West Yellowstone Trail, Po 368
Buffalo Lake, MN 55314

RE: CCN: 245589
Cycle Start Date: December 22, 2020

Dear Administrator:

On December 22, 2020, a survey was completed at your facility by the Minnesota Department(s) of Health 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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 Region V Office for imposition. The CMS Region V Office 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 February 25, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 25, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 25, 2021.

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.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 $11,160; 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 February 25, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Buffalo Lake Health Care Ctr will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 25, 2021. 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)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

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 June 22, 2021 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:

Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@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
	245589	A. BUILDING _____ B. WING _____	12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUFFALO LAKE HEALTH CARE CTR	**703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314**

(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 A COVID-19 Focused Infection Control survey was conducted 12/21/20 through 12/22/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance. Because you are enrolled in ePOC, your 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 A COVID-19 Focused Infection Control survey was conducted 12/21/20 through 12/22/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was NOT in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880	Infection Prevention & Control	F 880		2/19/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/20/2021

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 880 SS=E	Continued From page 1 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 2 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure staff performed hand hygiene as instructed during the noon meal service delivery for 5 of 5 residents (R1, R2, R3, R4, R5) to decrease the risk of infection transmission in the facility. This had the potential to affect all 46 resident in the facility during the focused infection control survey. Findings include:	F 880	It is the intent of the Buffalo Lake Healthcare Center to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility completed root cause analysis	

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F 880	Continued From page 3 On 12/21/20, at 11:55 a.m. during continued observation dietary cook (C)-A exited R1's room and immediately entered R2's room. C-A touched R2's recliner, tray table, readjusted R2's right leg brace velcro strap, raised the tray table and brought it closer to R2, opened a pop can, and conversed with R2. At 11:58 a.m. C-A exited R2's room and obtained two beverage glasses and a set of napkin wrapped silverware from a designated container located on a cart that contained beverages and non-food lunch items. After C-A filled the two glasses with beverages, she entered R3's room and placed the glasses on R3's tray table. After exiting R3's room, C-A obtained another set of silverware, a hot beverage mug, a glass, and filled them with beverages. C-A handed the filled mug and glass to an unidentified staff member after the staff member approached and asked for beverages for an unidentified resident. After, C-A filled a replacement mug and glass and entered R4's room. C-A placed the mug and glass on R4's tray table and moved R4's kleenex box that had been located on R4's tray table to another spot on the tray table. After exiting R4's room, C-A touched the beverage cart handle, mug tray, and obtained a mug and filled it. C-A handed the filled cup to RN-A who then entered R5's room with the mug. C-A obtained a set of silverware and a glass and filled it. C-A entered R5's room, placed the items on R5's tray table, placed a plastic lid on R5's mug, and pushed it onto the mug with her palm to secure it. After exiting R5's room, C-A entered R4's room and touched the back of R4's wheelchair while she conversed with R4. At 12:02 p.m. C-A exited R4's room and obtained a plate from the metal food warming cart. C-A touched numerous food container metal lids and serving	F 880	to determine the cause of the problem. Through the use of root cause analysis interventions were developed to prevent reoccurrence of the problem. The Director of Nursing/Infection Preventionist reviewed the hand hygiene policy and procedures to ensure they meet CDC guidelines. Education was completed for the Infection Preventionist/Director of Nursing and all dietary staff using the CDC Train module The Basics of Hand Hygiene for Healthcare Settings. All dietary staff completed this together demonstrated proper food/fluid handling using proper hand hygiene on 1/5/2021. All other departments will complete this training and demonstrate competency of proper hand hygiene by February 15, 2021. The Director of Nursing/Infection Preventionist or designee will conduct audits in relation to the proper hand hygiene on all shifts every day for one week. If compliance is obtained audits will decrease to weekly on random shifts x 4 weeks and then monthly ongoing. Ongoing hand washing audits will be completed monthly per the facility infection control program. Results of the audits will be reported the QAPI team quarterly for review and input.	

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F 880	Continued From page 4	F 880		

utensils while she placed food items on the plate. Further, C-A touched the dessert tray and an individual serving dessert bowl. At 12:04 p.m. C-A brought the plate and dessert bowl to R4 and unfolded R4's set of silverware. After, C-A exited R4's room she entered R2's room. C-A had her hands in her pockets as she conversed with R2 about R2's lunch preferences. C-A exited R2's room, obtained a plate off of the serving cart and touched numerous food container lids, serving spoons, drawer handles, a piece of paper in one of the drawers, a knife used to cut a potato, condiment packages, and salt and pepper shakers. After, C-A brought R2 the lunch plate, unfolded the silverware from the napkin, touched the silverware, placed the napkin on R2's chest, and opened a pop can. At 12:08 p.m. C-A exited R2's room and proceeded to push the beverage cart off of the unit. During the entire continued observation, C-A had failed to perform hand hygiene upon exiting or entering R1, R2, R3, R4, and R5's rooms.

When interviewed on 12/21/20, at 12:10 p.m. C-A stated she had been trained on hand hygiene. She explained each resident room had sanitizer available for use and that she was to perform hand hygiene when entering and exiting a resident's room. C-A explained she typically does not perform hand hygiene when going into a resident room but will use the sanitizer when exiting. Further, C-A explained she had used the sanitizer in two of the resident rooms during the continued observation; however, stated she "forgot on the rest of them." In addition, C-A had been unable to verbalize any potential risk to the residents due to her having failed to perform hand hygiene when she dished up resident food and interacted with each resident; instead, she stated,

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F 880	Continued From page 5	F 880		

"It has been hectic."

During interview on 12/21/20, at 12:41 p.m. dietary manager (DM) stated she expected dietary staff to perform hand hygiene when entering and exiting resident rooms and when working directly with food items. DM explained the dietary staff were at increased risk for spreading "COVID or whatever that person might have" to other residents if facility policies and expectations were not followed during meal services.

When interviewed on 12/21/20, at 1:26 p.m. the director of nursing/infection control preventionist (DON) stated she expected all staff to perform hand hygiene when entering and exiting resident rooms. The DON explained that it may be harder for hand hygiene upon entering a resident's room if a staff member were to be carrying an item, such as a meal plate; however, she stated staff should at a minimum perform hand hygiene "between residents." The DON verbalized there was a potential risk of bringing a virus or bacteria into a resident's room which "could get others sick" if staff did not follow hand hygiene instructions.

A facility policy for Safe Food Procedure, undated, identified food safe sanitizer was to be used after handling food items and between residents. Further, the policy directed staff to sanitize their hands prior to serving any food or fluids.