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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: GGOI
Facility ID: 00714

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245513**

2.STATE VENDOR OR MEDICAID NO. (L2) **066663700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKE RIDGE CARE CENTER OF BUFFALO**
(L4) **310 LAKE BOULEVARD**
(L5) **BUFFALO, MN** (L6) **55313**

4. TYPE OF ACTION: **7** (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **02/01/2004**

6. DATE OF SURVEY **01/8/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **01/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **63** (L18)

13.Total Certified Beds **63** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	63			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor — 01/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 01/29/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **02/01/1988** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 01/29/2015 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **01/08/2015** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245513
Electronically delivered January 29, 2015

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

Dear Mr. Nelson:

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

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

Effective December 29, 2014 the above facility is certified for or recommended for:

63 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 63 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 27, 2015

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

****THIS LETTER REPLACES OUR PREVIOUS DOCUMENT DATED 1/20/2015****

RE: Project Number S5513024

Dear Mr. Nelson:

On December 9, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 20, 2014 that . This survey found the most serious deficiencies 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) whereby corrections were required.

On January 8, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 24, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 20, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 29, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 20, 2014, effective December 29, 2014 and therefore remedies outlined in our letter to you dated December 9, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 21, 2015

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

RE: Project Number S5513024

Dear Mr. Nelson:

On December 9, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 20, 2014. This survey found the most serious deficiencies 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) whereby corrections were required.

On January 8, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 24, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 20, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 29, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 20, 2014, effective December 29, 2014 and therefore remedies outlined in our letter to you dated December 9, 2014, will not be imposed.

However, as we notified you in our letter of December 9, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from NO DATA.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245513	A. Building B. Wing	1/8/2015

Name of Facility	Street Address, City, State, Zip Code
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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

(Y4) Item ID Prefix	Reg. #	LSC	(Y5) Date Correction Completed
F0279	483.20(d), 483.20(k)(1)		12/22/2014
F0282	483.20(k)(3)(ii)		12/22/2014
F0311	483.25(a)(2)		12/22/2014
F0312	483.25(a)(3)		12/22/2014
F0314	483.25(c)		12/22/2014
F0315	483.25(d)		12/22/2014
F0318	483.25(e)(2)		12/22/2014
F0353	483.30(a)		12/29/2014
F0356	483.30(e)		12/15/2014

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/KJ	1/21/2015	34764	1/8/2015

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/20/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245513	01 - MAIN BUILDING 01	12/24/2014

Name of Facility	Street Address, City, State, Zip Code
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	12/15/2014	ID Prefix Reg. # NFPA 101 LSC K0062	12/19/2014	ID Prefix Reg. # NFPA 101 LSC K0147	11/24/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KJ	1/21/2015	34764	12/24/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/18/2014				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: GGOI
Facility ID: 00714

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245513
2. STATE VENDOR OR MEDICAID NO. (L2) 066663700

3. NAME AND ADDRESS OF FACILITY
(L3) LAKE RIDGE CARE CENTER OF BUFFALO
(L4) 310 LAKE BOULEVARD
(L5) BUFFALO, MN (L6) 55313

4. TYPE OF ACTION: 2 (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 02/01/2004
6. DATE OF SURVEY 11/20/2014 (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) 01/31

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds 63 (L18)
13. Total Certified Beds 63 (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: B* (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	63			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE: Carol Bode HFE NE II — Date: 01/05/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL: Kate JohnsTon, Enforcement Specialist — Date: 01/07/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION 02/01/1988 (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. 03001 (L31)

30. REMARKS
Posted 01/08/2015 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 9, 2014

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

RE: Project Number S5513024

Dear Mr. Nelson:

On November 20, 2014, a standard survey was completed at your facility by the Minnesota Departments 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 30, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by February 20, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 20, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

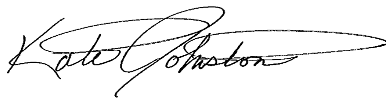
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

POC NOT FINAL

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 ______	11/20/2014

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

(X4) ID 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 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		12/22/14

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

Electronically Signed — 12/19/2014

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 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan to include a toileting program for 1 of 3 residents (R91) reviewed for urinary incontinence. Findings include: R91's admission Minimum Data Set (MDS), dated 9/26/14, identifed R91 had severe cognitive impairment, was frequently incontinent of urine, and required extensive assistance of two staff to complete toileting. Review of R91's Nursing Observations assessment, dated 9/26/14, indicated she was always incontinent of urine, and suffered from functional incontinence (caused by inability to get to the toilet per self or in a timely fashion). R91 required assistance with toileting, was unable to ask for toileting assistance, was unable to participate in a toileting program, and should be checked for incontinence and changed (if needed) every 2 hours. R91's care plan, dated 10/9/14, identified R91 was incontinent of bowel and bladder, and was unaware of the need to void or defecate. The care plan did not identify a toileting program, nor how often to assist R91 to the toilet or provide incontinence care. During continous observation, starting on 11/20/14 at 1:42 p.m., R91 was lying in her room, in bed with her eyes closed. Nursing assistant (NA)-C entered the room at 2:10 p.m., and	F 279	F279-D This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Lake Ridge Care Center to develop comprehensive care plans for toileting programs related to urinary incontinence. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The cited resident is no longer at this facility. 2.Actions taken to identify other potential residents having similar occurrences: Care plans and care assignments have been reviewed and revised to meet the needs of residents who have urinary incontinence. 3.Measures put in place to ensure deficient practice does not recur: Toileting programs have been and will be assessed at admission, return from hospital, quarterly and with each change of condition. The Director of Nursing or	

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F 279	Continued From page 2 observed R91, however did not assist R91 with incontinence or toileting before leaving the room. NA-C entered the room at 3:57 p.m. and offered to assist R91 with her range of motion (ROM) exercises. NA-C offered to check R91 for incontinence at 4:03 p.m., and R91 had been incontinent of urine, 2 hours and 21 minutes. At 4:03 p.m., NA-C stated R91 had not been assisted with toileting or incontinence care since 1:00 p.m. (3 hours and 3 minutes) that afternoon because of being short staffed. NA-C stated R91 should be offered the toilet/incontinence care every 2 hours. NA-C was unaware what R91's care plan did not identify how often to assist her with incontinence care. When interviewed on 11/20/14 at 4:14 p.m., registered nurse (RN)-C stated R91 should be checked for incontinence every 2 hours; however R91's care plan lacked any guidance on how often R91 should be assisted with toileting or incontinence care. During interview on 11/20/14 at 4:21 p.m., RN-A stated R91 had been recently re-admitted to the facility from being hospitalized for a urinary tract infection and should be checked or assisted with incontinence care every 2 hours, but this was not identifed in the care plan for R91. When interviewed on 11/20/14 at 4:41 p.m., the director of nursing (DON) stated the care plan should identify how often to help a resident, including R91, to the toilet or complete incontinence care. A policy on care planning was requested, but none was provided.	F 279	designee will perform weekly, random audits of care plans for toileting programs related to urinary incontinence. Re-education was completed with the clinical management team on developing individualized care plans regarding toileting needs. 4.Effective implementation of actions will be monitored by: The Director of Nursing or designee will choose at random two care plans per week and will review for compliance appropriately assessed toileting programs for three months, and one care plan per week for an additional three months. A summary of that compliance will be submitted to the QAPI committee for two quarterly meetings. 5.Those responsible to maintain compliance will be: The Director of Nursing or designee is responsible for maintaining compliance in developing comprehensive care plans for toileting programs related to urinary incontinence. Completion date for certification purposes only is: December 22, 2014	

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F 282	Continued From page 3	F 282		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to consistently implement care planned interventions for bathing, restorative nursing, and skin care prevention for 7 of 33 residents (R121, R22, 66, R73, R42, R5, and R18) in the sample reviewed for care plan implementation. Findings include: BATHING R121's admission minimum data set (MDS) dated 9/17/14, indicated she was cognitively intact and needed limited assist of one with dressing, bathing and grooming. R121's care plan dated 10/15/14, indicated she needs assist with all ADL's (activities of daily living) and assist of one for weekly bathing. During interview 11/19/14, at 9:01 a.m. nursing assistant (NA)- D stated the facility is short staffed and baths and showers are not getting done as they are scheduled. NA-D provided the bath sheets which indicated R121's bath was not signed off as given. NA-D stated we "were probably short-staffed and the bath didn't get done".	F 282	F282-E This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Lake Ridge Care Center to provide care plan interventions consistently regarding bathing, restorative nursing and skin care prevention. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: BATHING-Residents that were cited for not having care plan interventions followed consistently regarding bathing have and will continue to receive routine bathing to continue good personal hygiene, as noted in the POC for F-312. AMBULATION-Residents who were cited for not having care plan interventions	12/22/14

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F 282	Continued From page 4 During observation 11/19/14, at 11:50 a.m. R121 was observed to be sitting in her wheelchair in the dining room. At 11:59 a.m. R121 stated she just returned to the facility on 11/7/14, so she did not get her bath that week and on 11/14/14, as scheduled. R121 stated, "The staff never offered to give me my bath and I am going home on Friday so I guess I can take a bath when I go home. It has been over two weeks since I took a bath." During interview 11/20/14, at 12:00 p.m. the director of nursing (DON) stated if the staff are unable to give a bath they are supposed to report it so the next shift can give it. The DON verified the bath was not documented as given. R22's quarterly MDS, dated 10/28/2014, indicated intact cognition, and further that she required the assistance of one for bathing. The care plan (CP) for R22, dated 6/12/2014, identified an alteration in dressing, grooming, and bathing related to weakness. The CP included the intervention "assist of 1 for weekly bathing" for R22. During observation on 11/17/2014 at 2:16 p.m., resident was noted to be dressed for the day, sitting on her bed and adjusting an earring. During an interview on 11/18/2014 at 1:39 p.m., R22 stated she presently gets one shower a week, and added "I'm lucky I get even that. Sometimes they're too busy. They did not have enough staff on to help me." R22 went on to say "I missed a shower for almost 2 weeks when I came into the nursing home near the end of	F 282	followed consistently regarding ambulation have had their restorative ambulation programs assessed and adjusted to maintain or improve their ambulation ability, as noted in the POC for F-311. ROM-Residents who were cited for not having care plan interventions followed consistently regarding ROM have had their ROM programs adjusted to be provided more consistently to maintain or increase their ROM, as noted in the POC for F-318. SKIN CARE-The resident who was cited for not having care plan interventions followed consistently regarding skin care prevention will continue to have monitoring and assessment of current skin issues to prevent the potential reoccurrence of a pressure ulcer, as noted in the POC for F-314. 2.Actions taken to identify other potential residents having similar occurrences: BATHING-All residents that receive bathing have and will be evaluated to continue receiving routing bathing to continue good personal hygiene. AMBULATION-All residents who could benefit from a restorative ambulation program have had their program assessed and adjusted to maintain or improve their ambulation ability. ROM-All residents who have been assessed that may benefit from a ROM program have had their ROM programs adjusted to be provided more consistently to maintain or increase their ROM. SKIN CARE-All residents have and will	

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F 282	Continued From page 5 May." R22 then stated that her family stepped in, "I finally got my weekly shower." A review of "Point of Care History" for R22's bathing, indicated she had a shower on 5/31/2014, then again on 6/13/2014. The document indicated that on 6/7/14 and 6/12/14, R22 received "Partial" bed baths. There was no indication R22 had received a shower between 5/31/14 and 6/13/2014. A review of "Bath Day Body Audit" forms for R22 indicated 6/13/2014 was the first such record for her. During an interview on 11/20/2014 at 2:33 p.m., registered nurse (RN)-D said when a bath or shower was given, "...it is recorded in Matrix (a computer program) or on a resident's body audit sheet." RN-D could not determine if R22 had a bath between 5/31/14 and 6/13/2014. A facility bathing policy was requested, but none was provided. Restorative Nursing: Ambulation R66's quarterly minimum data set (MDS) dated 9/30/14, included diagnoses of dementia, had severe cognitive impairment, needed assist of one with ambulation. R66's care plan dated 10/14/14, indicated she received a restorative nursing program, ambulate 150 feet bid (twice a day) with assist of one and a transfer belt and AROM (active range of motion) to promote the resident's ability to maintain or restore function to the highest level of physical	F 282	continue to have skin monitoring and assessment completed with their weekly bathing to prevent potential pressure ulcer reoccurrence. 3.Measures put in place to ensure deficient practice does not recur: BATHING-Bathing will be scheduled and followed and each resident will receive at least one full body bath once per week and will be recorded on the bath sheet by the nurse and nursing assistant. If a resident refuses or is not available for their scheduled weekly bath, a make-up bath will be scheduled with the resident at a mutually agreed upon time with a nurse and will be documented by that nurse as to having been refused and/or unavailable and was rescheduled on the bath sheet. AMBULATION-Nursing will assess all residents who may benefit from a restorative ambulation program on admission, as needed, upon discharge from therapy and on a quarterly basis. When a resident starts a restorative ambulation program, the care plan will be updated along with a Restorative Nursing Program sheet. The nurse of the unit will monitor the restorative ambulation program for their residents and will be responsible to make sure that nursing assistants are completing the restorative ambulation programs per the goals of the care plan. ROM-A policy has been written regarding ROM programs. Nursing will assess all residents who may benefit from a ROM program on admission, as needed, upon discharge from therapy and on a quarterly	

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Continued From page 6

functioning. A Nursing Assistant care sheet undated indicated to ambulate with assistance of one with rolling walker 100 feet or as tolerated and AROM daily.

The facility RN (registered nurse) Restorative Nursing Monthly Review dated 10/28/14, indicated R66 was at risk for activity's of daily living related to diagnosis and condition. The review indicated R66's ambulation goal was not met and had only ambulated four times in the last 30 days, and has had recent medical issues, and weakness. The review indicated that there were no changes at this time continue with care plan. R66's AROM goal indicated goal met continue to comb own hair and apply her makeup, did have refusals due to condition in last 30 days continue plan of care.

Review of Point of Care History indicated the following:

September 2014- ambulated 11 times out of 60 opportunities. The history indicated she was unavailable three times, deferred due to condition 8 times. The history did not indicate why R66 did not ambulate the remainder 38 times.

October 2014- ambulated 14 times out of 62 opportunities. The history indicated she was unavailable once, refused once, not observed twice and deferred due to condition four times. The history did not indicate why R66 did not ambulate the remainder 40 times.

November 1st thru November 19th 2014- ambulated 11 times out of 38 opportunities. The history indicated she was unavailable three times and deferred due to condition three times. The

F 282

basis. When a resident starts a ROM program, the care plan will be updated along with a Restorative Nursing Program sheet. The nurse of the unit will monitor the ROM program for their residents and will be responsible to make sure that nursing assistants are completing the ROM programs per the goals of the care plan. Activities programming includes 3-5 facility exercise programs weekly on a routine basis, which include exercises for both upper and lower extremities. Activities will update nursing if residents involved in these programs are no longer attending so programs can be adjusted. SKIN CARE-Thorough inspections of skin integrity will be done with all new admissions, hospital returns and along with weekly bathing by the nurse of that unit on the Skin Assessment Audit form. Any potential skin issues will be communicated to the Clinical Coordinator and Director of Nursing so assessment can be made, care plan updating can be completed and needed interventions can be put in place to prevent further breakdown or progression of wounds.

4.Effective implementation of actions will be monitored by:
BATHING-Each unit nurse will be responsible for monitoring that bathing is done for each resident on that unit and will be confirmed by signing the bath sheet for each weekly bath. Those bathing documents will be reviewed weekly by the Director of Nursing for compliance for three months, and then monthly. Performance on the effectiveness of

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F 282	Continued From page 7 history did not indicate why R66 did not ambulate the remaining 27 opportunities. During interview 11/19/14, at 9:01 a.m. nursing assistant (NA)-D stated she is unable to ambulate R66 at times due to not having enough staff in the facility. During interview 11/20/14, at 10:42 a.m physical therapy assistant (PTA)-A stated R66 was in therapy and had been refusing so she had been placed on a restorative nursing rehab program. If the nurses note a decline or if a resident is refusing they are supposed to inform therapy of these changes. The PTA-A stated the nursing staff had not informed her R66 had not been ambulating or were unable to complete the restorative nursing due to staffing concerns but stated "I see them running around and they seem very busy here". During observation 11/20/14 at 11:44 a.m. Physical Therapist (PT)-G was ambulating R66 in the hallway with a rolling walker and transfer belt 130 feet. The PT-G stated R66 has not declined in her ambulation. R73's quarterly MDS dated 09/09/14, indicated he had hypertension and was moderately cognitively impaired needed assist of one to walk in corridor and used a walker and a wheelchair. R73's CAA dated 1/26/14, indicated he needed assistance with all ADL's due to Parkinson's Disease and dementia. The CAA further indicated he was attending PT and OT (occupational therapy) services but making very little progress.	F 282	completed bathing schedules will be presented to the QAPI committee for two consecutive quarters for continued compliance. AMBULATION-Monitored and completed Restorative Nursing Program sheets will be collected by the Director of Nursing from the unit nurses on a weekly basis to insure completeness proper procedures have been followed. A summary activity report of the restorative ambulation program compliance will be provided to the QAPI committee quarterly meeting for two quarters, and then as needed at the discretion of the QAPI committee. ROM-Monitored and completed Restorative Nursing Program sheets will be collected by the Director of Nursing from the unit nurses on a weekly basis to insure completeness proper procedures have been followed. A summary activity report of the ROM program compliance will be provided to the QAPI committee quarterly meeting for two quarters, and then as needed at the discretion of the QAPI committee. SKIN CARE-The Director of Nursing will collect and monitor the Skin Assessment Audit forms monthly for continued compliance and follow-up for six months. The Director of Nursing will report skin assessment and monitoring compliance to the QAPI committee for two quarters. Further need for monitoring will be evaluated by the QAPI committee. 5.Those responsible to maintain compliance will be: The Director of Nursing or designee will	

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R73's care plan dated 2/25/14, indicated he received restorative nursing ambulation to promote his ability to maintain or restore function to the highest level of physical functioning. R73 was to ambulate with assist of one and rolling walker 200 feet or as tolerated. R73's nursing assistant care sheet indicated he was to ambulate with rolling walker and assist of one with w/c (wheelchair) to and from meals and 100 feet or as tolerated BID (twice a day).

R73's Restorative Nursing Program dated 04/09/14, initiated by a unknown PTA indicated walking program assist of rolling walker and transfer belt BID.

Review of R73's RN Restorative Nursing Monthly Review dated October 2014, indicate "Resident walked 200' (feet) five out of 26 days. Resident did have increase in a antiparkinson's medication and antidepressant medication 10/08/14. Resident tolerated ambulating fair. Will continue POC (plan of care)."

The Point of Care History indicated the following:

September 2014- ambulated 14 times out of 60 opportunities, refused 3 times, deferred due to condition 8 times. The history did not indicate the reason why R73 did not ambulate the remaining 37 times.

October 2014- ambulated 21 times out of 62 opportunities, refused once, not observed 8 times and deferred due to condition 7 times. The history did not indicate why he did not ambulate the remaining 26 times.

November 1st thru November 19th 2014-

Provider's Plan of Correction (F 282):

be responsible for maintaining compliance with consistently implementing care plan interventions for bathing, ambulation, ROM and skin care.

Completion date for certification purposes only is: December 22, 2014

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F 282	Continued From page 9 ambulated 14 times out of 38 opportunities, refused 3 times, deferred due to condition 8 times. The history did not indicate why R73 did not ambulate the remaining 24 times. During interview 11/20/14, at 10:45 a.m. PTA-A stated she has not been referred to see R73 and could not remember when he was seen by therapy last. R42's quarterly MDS dated 09/16/14, indicated she had arthritis and was cognitively intact ambulated with limited assist of two in corridor and used a walker and a wheelchair. R42;s ADL CAA indicated she needed assistance with ADL's has attended PT and OT in the past and at her highest level of function and had a restorative program in place. R42's care plan dated 6/28/14, indicated she had alteration in mobility related to weakness and ambulates per restorative program assist of one and walker. The facility had a Therapy Assessment- PT Progress note PRO REHAB dated 09/06/13, indicated it was her last day of therapy and was to continue with nursing and walking BID (twice a day). The facility Restorative Nursing Program dated 10/19/11, initiated by PTA-A indicated R42 was to ambulate 100 feet with rolling walker, and transfer belt twice a day. A RN Restorative Nursing Monthly Review dated 10/21/14, indicated R42 ambulated 100 feet 25	F 282		

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F 282	Continued From page 10 days out of 30. Resident continues to ambulate less than 100 feet and is not completing daily. At least 50% of days in the past month she tolerates well and program was changed to qod (every other day) to reflect residents current progress see care plan for further details. Although the note indicated the program was changed from bid to qod the Restorative Nursing Program did not identify these changes. Review of the Point of Care History indicated the following: September 2014- ambulated 35 times out of 60 opportunities, not observed twice and no information was documented once. The history did not indicate why R42 did not ambulate the remaining 22 times. October 2014- ambulated 34 times out of 62 times, and there was no information 14 times. The history did not indicate why R42 did not ambulate the remaining 48 times. November 1st thru November 19th 2014- ambulated 22 times out of 38, there was no information 8 times. The history did not indicate why R42 did not ambulate the remaining 16 times. During interview 11/19/14, at 9:01 a.m. NA- D stated she is the only one working on her unit today for 13 residents and they should have two NA's on her unit. NA-D said this happens at least once a week and because of that sometimes the restorative nursing programs.	F 282		

POC NOT FINAL

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During interview 11/20/14, at 10:51 a.m. PTA-A verified the Restorative Nursing Program indicated R42 should ambulate BID. PTA-A also indicated the restorative nursing rehab program sheet are given to the clinical coordinator and they are responsible to let us know if the resident is declining or not participating in the program. The PTA-A stated she had been told the restorative nursing programs were not being implemented.

During interview 11/20/14, at 11:25 a.m. with PT-A stated the clinical coordinators are in charge of the restorative program and they thought the DON oversaw the program also. The PT-A stated the nursing staff are to inform us if a resident was not participating, had a decline or an injury with a fall. The PT-A stated they were not informed the restorative programs were not being completed.

During interview 11/20/14, at 12:05 p.m., the DON stated there have been some days where there just isn't enough staff to complete the restorative programs and there are days she was working on the floor and knows it just can not get completed.

During interview 11/20/14, at 1:50 p.m. with clinical coordinator registered nurse (RN)-D stated the nursing assistance are to complete there restorative nursing and she was not informed they were unable to complete there programs for the above residents as written.

R5's quarterly MDS dated 10/07/14, indicated she had seizure disorder and hypertension. The MDS further indicated she was cognitively intact and needed extensive assist of two with dressing, and

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F 282	Continued From page 12	F 282		

assist with personal hygiene and had no impairment on her upper extremity (UE) and lower extremity (LE). R5's care area assessment (CAA) dated 10/07/14, indicated she needed assistance with ADL's (activity of daily living) due to weakness related to osteoarthritis and is at her highest level of functioning.

R5's care plan dated 08/05/14, indicated she needs assist with dressing, bathing and grooming needs assist of one to two with all ADL's. The care plan indicated she received AROM.

Occupation Therapy note dated 10/26/11, indicated she received OT pt had limited UE ROM and fatigued easily with tasks and she participated in upper body dressing and maximum assist with LE dressing. The note further indicated for patient to resume restorative nursing program.

Restorative Nursing Program recommended by "therapies" dated 10/21/11, indicated she was to receive AROM to UE and LE for 15 minutes once a day.

RN Restorative Nursing Monthly Review dated 10/21/14, indicated she had no changes in her ROM/voluntary movement and did not need OT referral. The summary of her goal of to continue to dress upper half of body and use stand for transfers indicated she continues to complete AROM program with meeting goal. Has completed 27 out of 30 days. Tolerates fair to good, goal appropriate unable to progress to higher level continue to maintain current mobility with no decline.

The Point of Care History indicated the following:

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September 2014- AROM occurred 15 minutes or greater 18 out of 30 opportunities, and refused 3 times. The history did not indicate why she did not receive AROM the remaining 12 times.

October 2014- AROM 27 out of 31 opportunities and refused once. The history did not indicate why she did not receive ROM the remaining four days.

November 1st thru November 19th 2014- AROM received for 15 minutes or more occurred 16 out of 19 opportunities. The history did not indicate why R5 did not receive AROM for 15 minutes or greater the remaining 3 opportunities.

During interview 11/19/14, at 9:01 a.m. NA- D stated she is the only one working on her unit today for 13 residents and they should have two NA's on her unit. NA-D said this happens at least once a week and because of that sometimes the restorative nursing programs cant get done.

During interview 11/20/14, at 11:25 a.m. with PT who stated the clinical coordinators are in charge of the restorative program and thought the DON oversaw the program also. The PT stated the nursing staff are to inform us if a resident is not participating, has a decline or has an injury with a fall. The PT stated they were not informed the restorative programs were not being done.

During interview 11/20/14, at 12:05 p.m., the DON stated there have been some days where there just isn't enough staff to complete the restorative programs and there are days she is working on the floor and knows it just cant get done.

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During interview 11/20/14, at 1:50 p.m. with clinical coordinator registered nurse (RN)-D who stated the nursing assistance are to complete there restorative nursing and that she was not informed they were unable to complete there programs.

RESTORATIVE NURSING ROM
R66's quarterly minimum data set (MDS) dated 9/30/14, included diagnoses of dementia, had severe cognitive impairment, no limitation in upper (UE) and lower extremity (LE).

R66's care plan dated 10/14/14, indicated she received a restorative nursing program, AROM (active range of motion) daily to promote the resident's ability to maintain or restore function to the highest level of physical functioning.

During observation 11/19/14, at 12:00 p.m. R66 was observed to be in her wheelchair wheeling down the hall independently, there was no indication that R66 recieved her AROM excercise program.

The RN (registered nurse) Restorative Nursing Monthly Review dated 10/28/14, indicated R66 was at risk for ADL decline related to diagnosis and condition. The Review indicated R66's AROM goal was met and to continue to comb own hair, apply makeup, and had some refusals due to medical condition in last 30 days but to continue plan of care.

The facility had a Therapy Assessment -- 701 FORM Occupational Therapy form dated 7/22/14, indicated R66's Occupational Therapy (OT) was discontinued due to hospitalization with possible

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cellulitis to hand. The form identified "Res (resident) DC (discontinued) rx (treatment), dc to hosp with possible cellulitis to hand. At time of dc res was not participation with therapy refused last 2 sessions and needed max verbal and tactile cues to participate the other dates of service. She was able to propel wc short distances in SNF (skilled nursing facility) using LE (lower extremity) however did use UE (upper extremity) on occasion or when cued to do so." Although OT was discontinued on 7/22/14, the form did not identify if restorative nursing program was to be implemented or not.

Review of the Restorative Nursing Program dated 2/14/14 which was recommended by physical therapy assist (PTA)-A indicated AROM program to UE (upper extremity) and LE (lower extremity) once a day.

Review of Point of Care History indicated the following:

September 2014-AROM completed 30 times out of 30 opportunities.

October 2014- AROM completed 16 times out of 31 opportunities, deferred due to condition three times and not observed twice. The Point of Care History did not indicate why R66 did not receive AROM the remaining 10 opportunities.

November 1st thru November 19th 2014- AROM completed 10 times out of 19 opportunities, the Point of Care History did not indicate why R66 did not receive AROM the remaining 9 opportunities.

During interview 11/19/14, at 9:05 a.m. NA- D

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stated they are short staffed and she is unable to complete AROM on R66 a lot of the time due to not having enough time.

During interview 11/20/14, at 11:25 a.m. OT-A stated she was not aware that R66 was not receiving her AROM according to her plan of care. OT-A further stated the clinical coordinators are supposed to let therapy know if residents are not completing there programs and they had not with R66.

During observation 11/20/14, at 11:50 a.m. the OT-A was observed to provide AROM with R66 and stated the resident remained unchanged and that she still has full ROM.

R42's quarterly MDS dated 9/16/14, indicated she was cognitively intact, had hypertension and anemia. The MDS further indicated she needed extensive assist of one with ADL's and had impairment on onside of her UE and no impairment on her LE. R42's CAA dated 4/15/14, indicated she needed assistance with all ADL's due to multiple diagnosis including arthritis. Has attended PT and OT in the past and was at her highest level of function, restorative program in place.

R42's care plan dated 10/21/14, indicated she received AROM to promote her ability to maintain or restore function to the highest level of physical functioning. The care plan indicated she needed AROM to UE and LE daily for 15 minutes may include seated leg exercises, thera-band, hand gripper or squeeze ball.

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The Therapy Assessment Occupational Therapy dated 09/06/13, completed by OT, indicated she received OT five times a week for 23 sessions and met goals with bilateral UE she has low motivation and no longer required OT services and was discontinued. R42 was to stay long term and participate on nursing restorative and walk program as tolerated.

Restorative Nursing Program dated 10/19/11, indicated she was receive AROM to UE and LE 15 minutes daily.

RN Restorative Nursing Monthly Review dated 10/21/14, indicated no need for OT referral and was to dress upper extremity with set up assist. The summary of of the goal indicated goal not appropriate. Staff assist with dressing change goal to a more appropriate one does continue to complete AROM program daily tolerates program fair to good. The summary also indicated she had no changes in her ROM voluntary movement since last review.

The Point of Care History indicated the following:
September 2014- AROM 29 out of 30 opportunities. The history indicated R42 received AROM several times at twice a day.

October 2014- received AROM 12 out of 31 opportunities, no information was documented five times. No information was provided why R42 did not receive AROM the remaining 14 times.

November 2014- received AROM 19 out of 19 opportunities.

During interview 11/19/14, at 9:07 a.m. NA- B who verified R42 does not receive her AROM

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F 282	Continued From page 18 consistently and that she should and when they are short staffed it is impossible to get her work done. R5's quarterly MDS dated 10/07/14, indicated she had seizure disorder and hypertension. The MDS further indicated she was cognitively intact and needed extensive assist of two with dressing, and assist with personal hygiene and had no impairment on her UE and LE. R5's care area assessment (CAA) dated 10/07/14, indicated she needed assistance with ADL's (activity of daily living) due to weakness related to osteoarthritis and is at her highest level of functioning. R5's care plan dated 08/05/14, indicated she needs assist with dressing, bathing and grooming needs assist of one to two with all ADL's. The care plan indicated she received AROM. Occupation Therapy note dated 10/26/11, indicated she received OT for limited UE ROM and fatigued easily with tasks. She participated in upper body dressing and maximum assist with LE dressing. The note further indicated for patient to resume restorative nursing program. Restorative Nursing Program recommended by "therapies" dated 10/21/11, indicated she was to receive AROM to UE and LE for 15 minutes once a day. RN Restorative Nursing Monthly Review dated 10/21/14, indicated she had no changes in her ROM/voluntary movement and did not need a OT referral. The summary of her goal was to continue to dress upper half of body and use	F 282		

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stand for transfers indicated she continues to complete AROM program with meeting goal. Has completed 27 out of 30 days. Tolerates fair to good, goal appropriate unable to progress to higher level continue to maintain current mobility with no decline.

The Point of Care History indicated the following:

September 2014- AROM occurred 15 minutes or greater 18 out of 30 opportunities, and refused 3 times. The history did not indicate why she did not receive AROM the remaining 12 times.

October 2014- AROM 27 out of 31 opportunities and refused once. The history did not indicate why she did not receive ROM the remaining four days.

November 1st thru November 19th 2014- AROM received for 15 minutes or more occurred 16 out of 19 opportunities. The history did not indicate why R5 did not receive AROM for 15 minutes or greater the remaining four opportunities.

During interview 11/19/14, at 9:01 a.m. NA- D stated she was the only one working on her unit today for 13 residents and they should have two NA's on her unit. NA-D said this happens at least once a week and because of that the restorative nursing programs can not get completed.

During interview 11/20/14, at 11:25 a.m. with PT-A stated the clinical coordinators were in charge of the restorative program and thought the DON oversaw the program also. PT-A stated the nursing staff are to inform us if a resident is not participating, has a decline or has an injury with a

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F 282	Continued From page 20 fall. They were not informed the restorative programs were not being completed as assessed. During interview 11/20/14, at 12:05 p.m., the DON stated there have been some days where there just isn't enough staff to complete the restorative programs and there are days she is working on the floor and knows it just can not get done. The DON stated the nursing staff had been trained in the restorative programs and they do not have a facility specific policy but they follow the RAI (resident assessment instrument) manual. During interview 11/20/14, at 1:50 p.m. with clinical coordinator registered nurse (RN)-D who stated the nursing assistance are to complete there restorative nursing and that she was not informed they were unable to complete there programs. The facility provided training 4/01/14 and 4/2/14 for the nurses and nursing assistance, on Restorative Nursing Programs. The training materials indicated "Each resident who is on a restorative nursing program has been assessed by the nurse and found to be appropriate and able to do the programs listed on the restorative program found in your care books behind the personal data sheet. Any information about the program including what programs and how often to do them can be found there and the Clinical Coordinator can answer any questions you may have about the program or address it if you find the resident is unable or unwilling to follow the program. Once you have been educated on the program for your resident, please sign/date at the bottom of the sheet. You are required to follow the restorative nursing programs for our residents	F 282		

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F 282	Continued From page 21 to be in compliance with their plan of care - so you do have an obligation here!". PREVENTATIVE SKIN CARE R18's five day assessment MDS dated 11/11/14, indicated intact cognition, at high risk for skin breakdown, left sided weakness from residual affects of recent stroke, assist of two person for transfers and assist of two persons for bed mobility. R18's care plan for skin integrity dated 10/14/14 indicated " potential in skin integrity related to seizures, decreased mobility due to recent arthritis, recent CVA (left sided weakness) history of stasis ulcers(open areas from poor venous circulation) and Parkinson's disease. At risk for pressure ulcers/ skin breakdown/injury. Avoid pressure to right ankle and encourage resident to reposition and put leg up on pillow (elevation to avoid pressure)." During observation of R18 on 11/19/14, at 7:04 a.m., R18 was in bed lying on his back slightly off center but not in a position to slide off of the bed. His head was supported with one pillow and head of bed was raised @ 30 degrees. He was sleeping quietly with no pillow under his bilateral legs for support. During observation of R18 on 11/19/14 at 2:01 p.m., R18 was observed lying on his back, there was no no pillow provided under his legs for support.	F 282		

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F 282	Continued From page 22 During observation of R18 on 11/20/14 at 2:28 p.m., R18 was on his back head elevated there was no pillow or support provided for his legs. During observation of R18 on 11/20/14 at 3:14p.m., R18 was in bed with HOB elevated, there was no pillow or support provided for his legs. Licensed practical nurse (LPN)-A who was in the room at this time verified R18's feet were to be floated on a pillow. NA-C who was also present stated his feet will not stay on a pillow. The facility assignment sheet titled LAKE RIDGE CARE CENTER CARE SHEETS, which is followed by nursing assistants for cares did not identify R18's legs were to be elevated as indicated in care plan dated 10/14/14. During an interview on 11/20/14 at 5:02 p.m., with the director of nursing (don) she stated the care plan should be followed for supporting his legs. She did state R18 has refused use of a pillow for elevation of legs but R18 should be re-approached or an alternate used to support legs. The clinical coordinators are responsible for updating the care plans and nursing staff on changes for residents' cares.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide and	F 311	F311-D This Plan of Correction constitutes my	12/22/14

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consistently implement restorative ambulation services to improve and/or maintain the resident's ambulation ability for 3 of 4 residents (R66, R73 and R42) reviewed for ambulation.

Findings include:

R66's quarterly minimum data set (MDS) dated 9/30/14, included diagnoses of dementia, had severe cognitive impairment, needed assist of one with ambulation. R66's care area assessment (CAA) dated 7/15/14, indicated she was at high risk for falls, had three falls in the last three months.

R66's care plan dated 10/14/14, indicated she received a restorative nursing program, ambulate 150 feet bid (twice a day) with assist of one and a transfer belt to promote the resident's ability to maintain or restore function to the highest level of physical functioning.

The Restorative Nursing Program dated 2/14/14 recommended by physical therapy assist (PTA)-A indicated a walking program 100 feet twice a day.

During observation 11/19/14, at 12:00 p.m. R66 was observed to be in her wheelchair wheeling down the hall independently using her hands and feet to propel.

During interview 11/19/14, at 9:05 a.m. NA- D stated they are not always able to ambulate R66 due to staffing. She indicated they are short all time and just can not get there restorative nursing done.

Review of the RN (registered nurse) Restorative Nursing Monthly Review dated 10/28/14,

F 311 (Plan of Correction)

written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law.

It is the policy of Lake Ridge Care Center that we provide and consistently implement restorative ambulation programs to our residents.

To assure continued compliance, the following plan has been put into place;

1. Regarding cited residents:
Residents who were cited have had their restorative ambulation programs reviewed and adjusted to maintain or improve their ambulation ability.

2.Actions taken to identify other potential residents having similar occurrences:
All residents who could benefit from a restorative ambulation program have had their program reviewed and adjusted to maintain or improve their ambulation ability.

3.Measures put in place to ensure deficient practice does not recur:
Nursing will assess all residents who may benefit from a restorative ambulation program on admission, as needed, upon discharge from therapy and on a quarterly basis. When a resident starts a restorative ambulation program, the care

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	245513	A. BUILDING ______ B. WING ______	11/20/2014

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LAKE RIDGE CARE CENTER OF BUFFALO	**310 LAKE BOULEVARD BUFFALO, MN 55313**

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indicated R66 is at risk for ADL decline related to diagnosis and condition. The Review indicated R66's ambulation goal was not met has only ambulated four times in the last 30 days, does have recent bleeding issues from rectum and weakness. No changes at this time continue with care plan. R66's AROM goal indicated goal met continue to comb own hair and apply her makeup, did have refusals due to condition in last 30 days continue plan of care.

The facility HCFA 701 (Health Care Finacing Administration) a (form used for medicare recetification of therapy) dated 7/08/14, indicated "PT was discontinued secondary to progressive weakness and decline in medical status and the patient was recently hospitalized due to decline in medical status. The form futher indicated she was transferring with moderate to minimal assist of one. Had ambulation with moderate assist of one up to 70 feet and d/c [discharge] was unexpected due to hospitalization." Although therapy was discontinued the form did not identify R66's restorative rehab nursing.

During interview 11/19/14, at 9:01 a.m. nursing assistant (NA)-D stated she was unable to ambulate R66 at times due to not having enough staff in the facility.

Review of Point of Care History indicated the following:

September 2014- ambulated 11 times out of 60 opportunities. The history indicated she was unavailable three times, deferred due to condition 8 times. The history did not indicate why R66 did not ambulate the remainder 38 times.

plan will be updated along with a Restorative Nursing Program sheet. The nurse of the unit will monitor the restorative ambulation program for their residents and will be responsible to make sure that nursing assistants are completing the restorative ambulation programs per the goals of the care plan.

4.Effective implementation of actions will be monitored by:
Monitored and completed Restorative Nursing Program sheets will be collected by the Director of Nursing from the unit nurses on a weekly basis to insure completeness proper procedures have been followed. A summary activity report of the restorative ambulation program compliance will be provided to the QAPI committee quarterly meeting for two quarters, and then as needed at the discretion of the QAPI committee.

5.Those responsible to maintain compliance will be:
The Director of Nursing or designee will be responsible for maintaining compliance with restorative ambulation programs.

Completion date for certification purposes only is: December 22, 2014

POC NOT FINAL

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October 2014- ambulated 14 times out of 62 opportunities. The history indicated she was unavailable once, refused once, not observed twice and deferred due to condition four times. The history did not indicate why R66 did not ambulate the remainder 40 times.

November 1st thru November 19th 2014- ambulated 11 times out of 60 opportunities. The history indicated she was unavailable three times and deferred due to condition three times. The history did not indicate why R66 did not ambulate the remaining 21 opportunities.

During interview 11/20/14, at 10:42 a.m PTA-A stated R66 was in therapy and had been refusing so she had been placed on a restorative nursing rehab program. If the nurses note a decline or if a resident is refusing they are supposed to inform therapy of these changes. The PTA-A stated the nursing staff had not informed her R66 had not been ambulating. The PTA-A also stated she was not informed the staff were unable to compete the restorative nursing due to staffing concerns but stated "I see them running around and they seem very busy here".

During observation 11/20/14 at 11:44 a.m. Physical Therapist (PT)-A was observed to ambulate R66 in the hallway by the dinning room with a rolling walker and transfer belt 130 feet, the PT stated R66 has not had a decline in her ambulation.

R73's quarterly MDS dated 09/09/14, indicated he had hypertension and was moderately cognitively impaired needed assist of one to walk in corridor and used a walker and a wheelchair. R73's CAA

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F 311	Continued From page 26 dated 1/26/14, indicated he needed assistance with all ADL's due to Parkinson's Disease and dementia. The CAA further indicated he is attending PT and OT services but making very little progress. R73's care plan dated 2/25/14, indicated he received restorative nursing ambulation to promote his ability to maintain or restore function to the highest level of physical functioning. R73 was to ambulate with assistance of one and rolling walker 200 feet or as tolerated. R73's nursing assistant care sheet indicated he was to ambulate with rolling walker and assist of one with w/c (wheelchair) to and from meals and 100 feet or as tolerated BID (twice a day). A Physical Therapy Evaluation dated 3/5/14, indicated he was referred back to PT due to improvement in medical stats had been seen recently by therapy with only minimal improvement. The evaluation further indicated he ambulates with short shuffle steps and narrow base of support and had decreased endurance. The facility HCFA 701 dated 4/4/14, form indicated "PT was discontinued and to perform exercise with nursing staff. Patient is going to remain long term care. Patient is now performing contact guard assist [CGA] with SBA [stand by assist] and a rolling walker. Patient received theraputic exercises, Nu-Step [exercise equipment], transfer and bed mobility training and gait training". R73's Restorative Nursing Program dated 04/09/14, intimated by PTA indicated walking program assist of rolling walker and transfer belt BID.	F 311		

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Continued From page 27

R73's RN Restorative Nursing Monthly Review dated October 2014, indicate "Resident walked 200' (feet) five out of 26 days. Resident did have increase in a antiparkinson's medication and antidepressant medication 10/08. Resident tolerated ambulating fair. Will continue POC (plan of care).

During observation 11/20/2014, at 4:50:21 PM observation lying in bed watching television.

The Point of Care History indicated the following:

September 2014- ambulated 14 times out of 60 opportunities, refused 3 times, deferred due to condition 8 times. The history did not indicate the reason why R73 did not ambulate the remaining 37 times.

October 2014- ambulated 21 times out of 62 opportunities, refused once, not observed 8 times and deferred due to condition 7 times. The history did not indicate why he did not ambulate the remaining 26 times.

November 2014- ambulated 14 times out of 60 opportunities, refused 3 times, deferred due to condition 8 times. The history did not indicate why R73 did not ambulate the remaining 35 times.

During interview 11/20/14, at 10:45 a.m. PTA-A stated he has not been referred to see R73 and can not remember when he was seen by therapy last.

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F 311	Continued From page 28 R42's quarterly MDS dated 09/16/14, indicated she had arthritis and was cognitively intact ambulated with limited assist of two in corridor and used a walker and a wheelchair. R42's CAA dated 04/17/14, indicated she triggered ADL's due to needing assistance with ADL's has attended PT and OT in the past and was at her highest level of function and had a restorative program in place. R42's care plan dated 6/28/14, indicated she had alteration in mobility related to weakness and ambulates per restorative program assistance of one and walker. A Therapy Assessment- PT Progress note PRO REHAB dated 09/06/13, indicated she ambulated with a rolling walker 100 feet and tranfered with SBA and CGA and was her last day of therapy and was to continue with nursing and walking BID. Restorative Nursing Program dated 10/19/11, initiated by PTA-A indicated walking program ambulate 100 feet with rolling walker, transfer belt 100 feet two times a day. A RN Restorative Nursing Monthly Review dated 10/21/14, indicated R42 ambulated 100 feet 25 days out of 30. Resident continues to ambulate less than 100 feet and is not completing daily but at least 50% of days in the past month she tolerates well changed to qod (every other day) to reflect residents current progress see care plan for further details. Although the note indicated the program was changed, the Restorative Nursing Program did not identify the changes. During observation 11/20/2014, at 4:56 p.m. R42	F 311		

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was observed sitting in dayroom by the elevator indicated she is waiting to go down stairs for supper. At 5:00 p.m. nursing assistant (NA)-K was observed to take R42 in her wheelchair into the elevator to bring down stairs and was not ambulated.

During interview 11/19/14, at 9:08 a.m. NA- B who verified R42 does not receive her ambulation program as identified, because they are short staffed and it is impossible to get her work done.

Review of the Point of Care History indicated the following:

September 2014- ambulated 35 times out of 60 opportunities, not observed twice and no information was documented once. The history did not indicate why R42 did not ambulate the remaining 22 times.

October 2014- ambulated 34 times out of 62 times, and information 14 times. The history did not indicate why R42 did not ambulate the remaining 48 times.

November 2014- ambulated 22 times out of 60, no information 8 times. The history did not indicate why R42 did not ambulate the remaining 38 times.

During interview 11/19/14, at 9:01 a.m. NA- D stated she was the only one working on her unit today for 13 residents and they should have two NA's on her unit. NA-D stated this happens at least once a week and because of that sometimes the restorative nursing programs can not get the residents rehab program completed.

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F 311	Continued From page 30	F 311		

During interview 11/20/14, at 10:51 a.m. PTA-A verified the Restorative Nursing Program should be completed twice a day. PTA-A also indicated the restorative nursing rehab program sheet is given to the clinical coordinator and they are responsible to let us know if the resident is declining or not participating in the program. The PTA-A stated she was aware the restorative nursing programs were not being completed as it should.

During interview 11/20/14, at 11:25 a.m. with PT-A stated the therapists work with nursing and initiate the nursing rehab program. The clinical coordinators are in charge of the restorative program and the director of nursing (DON) oversees the program. The PT-A stated the nursing staff are to inform us if a resident is not participating, has a decline or has an injury with a fall. The PT stated they were not informed the restorative programs were not being done.

During interview 11/20/14, at 12:05 p.m., the DON stated there have been some days where there just isn't enough staff to complete the restorative programs and there are days she was working on the floor and knows it just can not get completed. The DON further stated all of the nursing assistance have been trained in the restorative nursing programs and they do not have a specific policy for the program.

During interview 11/20/14, at 1:50 p.m. the clinical coordinator registered nurse (RN)-D stated the nursing assistance are to complete there restorative nursing and that she was not informed they were unable to complete there programs.

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F 311	Continued From page 31 The facility provided training 4/01/14 and 4/2/14 for the nurses and nursing assistance, on Restorative Nursing Programs. The training materials indicated "Each resident who is on a restorative nursing program has been assessed by the nurse and found to be appropriate and able to do the programs listed on the restorative program found in your care books behind the personal data sheet. Any information about the program including what programs and how often to do them can be found there and the Clinical Coordinator can answer any questions you may have about the program or address it if you find the resident is unable or unwilling to follow the program. Once you have been educated on the program for your resident, please sign/date at the bottom of the sheet. You are required to follow the restorative nursing programs for our residents to be in compliance with their plan of care - so you do have an obligation here!".	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine bathing for 2 of 3 residents (R121 and R22) who were dependent upon staff for activities of daily living.	F 312	F312-D This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an	12/22/14

POC NOT FINAL

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F 312	Continued From page 32 Findings include: R121's admission minimum data set (MDS) dated 9/17/14, indicated she was cognitively intact and needed limited assist of one with dressing, bathing and grooming. R121's care plan dated 10/15/14, indicated she needed assistance with all ADL's (activities of daily living) and assist of one for weekly bathing. During interview 11/19/14, at 9:01 a.m. nursing assistant (NA)- D stated the facility was short staffed. Baths and showers are not getting done as they are scheduled. NA-D provided the bath sheets which indicated R121's bath was not signed off as given. NA-D stated we "were probably short-staffed and the bath didn't get done". During interview 11/19/14, at 11:59 a.m. R121 stated she just returned to the facility on 11/7/14, and had not gotten her bath that week nor on 11/14/14, she stated "The staff never offered to give me my bath and I am going home on Friday so I guess I can take a bath when I go home. It has been over two weeks since I took a bath". During interview 11/20/14, at 12:00 p.m. the director of nursing (DON) stated if the staff are unable to give a bath they are supposed to report it so the next shift can give it. The DON verified the bath was not documented as given. R22's quarterly MDS, dated 10/28/2014, indicated intact cognition, and further that she required the assistance of one for bathing. The care plan (CP) for R22, dated 6/12/2014, identified an alteration in dressing, grooming, and bathing	F 312	admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Lake Ridge Care Center to provide routine bathing to residents to continue good personal hygiene. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Although one resident is no longer in the facility, the other resident has and will continue to receive routine bathing to continue good personal hygiene. 2.Actions taken to identify other potential residents having similar occurrences: All residents that receive bathing have and will be evaluated to continue receiving routing bathing to continue good personal hygiene. 3.Measures put in place to ensure deficient practice does not recur: Bathing will be scheduled and followed and each resident will receive at least one full body bath once per week and will be recorded on the bath sheet by the nurse and nursing assistant. If a resident refuses or is not available for their scheduled weekly bath, a make-up bath will be scheduled with the resident at a mutually agreed upon time with a nurse and will be documented by that nurse as to having been refused and/or unavailable	

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F 312	Continued From page 33 related to weakness. The CP included the intervention "assist of 1 for weekly bathing" for R22. During observation on 11/17/2014 at 2:16 p.m., resident was noted to be dressed for the day, sitting on her bed and adjusting an earring. During an interview on 11/18/2014 at 1:39 p.m., R22 stated she presently gets one shower a week, and added "I'm lucky I get even that. Sometimes they're too busy. They did not have enough staff on to help me." R22 went on to say "I missed a shower for almost 2 weeks when I came into the nursing home near the end of May." R22 then stated that her family stepped in, "I finally got my weekly shower." A review of "Point of Care History" for R22's bathing, indicated she had a shower on 5/31/2014, then again on 6/13/2014. The document indicated that on 6/7/14 and 6/12/14, R22 received "Partial" bed baths. There was no indication R22 had received a shower between 5/31/14 and 6/13/2014. A review of "Bath Day Body Audit" forms for R22 indicated 6/13/2014 was the first such record for her. During an interview on 11/20/2014 at 2:33 p.m., registered nurse (RN)-D said when a bath or shower was given, "...it is recorded in Matrix (a computer program) or on a resident's body audit sheet." RN-D could not determine if R22 had a bath between 5/31/14 and 6/13/2014. A facility bathing policy was requested, but none was provided.	F 312	and was rescheduled on the bath sheet. 4.Effective implementation of actions will be monitored by: Each unit nurse will be responsible for monitoring that bathing is done for each resident on that unit and that will be confirmed by signing the bath sheet for each weekly bath. Those bathing documents will be reviewed weekly by the Director of Nursing for compliance for three months, and then monthly. Performance on the effectiveness of completed bathing schedules will be presented to the QAPI committee for two consecutive quarters for continued compliance. 5.Those responsible to maintain compliance will be: The Director of Nursing or designee will be responsible for maintaining compliance of routine bathing being completed. Completion date for certification purposes only is: December 22, 2014	
F 314	483.25(c) TREATMENT/SVCS TO	F 314		12/22/14

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F 314 SS=D	Continued From page 34 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor and assess interventions of a current pressure ulcer on buttock and prevent pressure ulcer reoccurrence for 1of 3 residents (R18) identified as a high risk for pressure ulcers. Findings include: R18's PPS 5 day assessment Minimum Data Set (MDS) dated 11/11/14, indicated intact cognition, at high risk for skin breakdown, left sided weakness from residual affects of recent stroke, assist of two person for transfers and assist of two persons for bed mobility. R18's care plan for skin integrity dated 10/14/14 indicated " potential in skin integrity related to seizures, decreased mobility due to recent arthritis, recent CVA (left sided weakness) history of stasis ulcers(open areas from poor venous circulation) and Parkinson's disease. At risk for pressure ulcers/ skin breakdown/injury. Avoid pressure to right ankle and encourage resident to	F 314	F314-D This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Lake Ridge Care Center that we monitor and assess interventions of current pressure ulcers and prevent pressure ulcer reoccurrence in residents identified as a high risk for pressure ulcers. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The resident will continue to have monitoring and assessment of current	

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NAME OF PROVIDER OR SUPPLIER: **LAKE RIDGE CARE CENTER OF BUFFALO**

STREET ADDRESS, CITY, STATE, ZIP CODE: **310 LAKE BOULEVARD, BUFFALO, MN 55313**

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F 314	Continued From page 35 reposition and put leg up on pillow (elevation to avoid pressure). Skin checks are to be performed weekly and as needed. " During observation of R18 on 11/19/14 at 2:01 p.m., R18 was observed lying on his back head of bed was flat. R18's was head supported with one pillow and no pillow support was provided for his bilateral legs. During observation of personal cares with licensed practical nurse (LPN-A), on 11/20/14 at 2:53 p.m., R18 was incontinent of urine and had a shiny/reddened area that was approximately 1.5 centimeter length x 0.5 centimeter width on right buttock proximal to gluteal crease, there was no open area. Barrier cream was applied to entire area. R18 legs were dry and flaky skin but there was no signs of pressure or open areas on his legs or ankles. During observation of R18 on 11/20/14 at 3:14p.m., R18 was in bed with HOB elevated and feet covered by blankets without a pillow or elevation of feet. Licensed practical nurse (LPN-A) confirmed R18's feet were not floated on a pillow. The facility nursing assistant assignment sheet titled LAKE RIDGE CARE CENTER CARE SHEETS undated did not identify R18's feet should be elevated as identified by the 10/14/14 care plan. Review of R18's nursing progress note dated 11/4/14 at 1:15 p.m., indicated communication from St. Cloud Hospital that identified, "Writer spoke with RN at St. Cloud Hospital this a.m. shift. Resident will be returning to LRCC [facility] at approximately 12:00 or 1:00 pm this shift. Open area on right ankle, and a little open area	F 314	skin issues to prevent the potential reoccurrence of a pressure ulcer. 2.Actions taken to identify other potential residents having similar occurrences: All residents have and will continue to have skin monitoring and assessment completed with their weekly bathing to prevent potential pressure ulcer reoccurrence. 3.Measures put in place to ensure deficient practice does not recur: Thorough inspections of skin integrity will be done with all new admissions, hospital returns and along with weekly bathing by the nurse of that unit on the Skin Assessment Audit form. Any potential skin issues will be communicated to the Clinical Coordinator and Director of Nursing so assessment can be made, care plan updating can be completed and needed interventions can be put in place to prevent further breakdown or progression of wounds. 4.Effective implementation of actions will be monitored by: The Director of Nursing will collect and monitor the Skin Assessment Audit forms monthly for continued compliance and follow-up for six months. The Director of Nursing will report skin assessment and monitoring compliance to the QAPI committee for two quarters. Further need for monitoring will be evaluated by the QAPI committee. 5.Those responsible to maintain	

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under abdominal fold. Resident arrived at approximately 1:00 pm from St. Cloud Hospital this shift."

There was a note titled PHYSICAL SKIN EVALUATION dated 11/4/14 identified, sutures from surgery on left hip, multiple sites of bruising, and slit on abdomen. There was no indication there was an open area to the right ankle, which was identified by the nursing progress note on 11/4/14, there was an, "...open area on right ankle."

R18's had a current physician order dated 11/5/14 identified nursing staff to perform wound care to right open area on medial ankle. Apply Mepilex AG (a dressing specific to this open area) border and change dressing every other day.

Review of the facility medical record identified a PHYSICAL SKIN EVALUATION form dated 11/19/14 indicated R18 had an open area on his right gluteal fold which was 4 cm (centimeters) in length x 1cm width. There was no depth listed.

Review of facility bath audits for R18's were reviewed from 11/4/14 to 11/19/14. There was no indication that R18 had any open areas on R18's right ankle or buttock area.

During interview on 11/20/14 at 2:55 p.m. LPN-A examined the skin audits and confirmed there had been no assessments or tracking completed to monitor the pressure ulcers on R18's buttock or right ankle. LPN-A stated she would report any open area to her supervisor and see if new orders should be given such as a nutritional supplement to speed the healing.

compliance will be:
The Director of Nursing or designee is responsible for maintaining the compliance of monitoring and assessment of skin issues.

Completion date for certification purposes only is: December 22, 2014

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F 314	Continued From page 37 Even though R18 had a pressure ulcer on his ankle, when he returned from his hospitalization on 11/5/14, and a pressure ulcer on 11/19/14 on his buttock area. There was no indication these area were consistently measured, assessed and monitored to prevent additional pressure ulcers from developing. During interview on 11/20/14 at 5:02 p.m., the director of nursing (DON) stated she was not aware of any pressure ulcers for this resident. She confirmed there were nothing noted in the event part of our point click care nor any progress notes about the pressure ulcers. She stated the clinical coordinators are responsible for updating the care plans and nursing staff on changes for residents' cares. The coordinators are also required to document weekly skin audits which were not completed weekly. The DON confirmed the pressure ulcers should have been identified, and consistently monitored. Policy Titled PRESSURE ULCERS DOCUMENTATION - Elim Care revised June 2014 indicated that all resident will have skin audits done weekly by a licensed nurse. If a pressure ulcer is noted the nurse aide assignment sheet would be updated. Policy Titled WOUND PREVENTION AND TREATMENT- Elim Care revised June 2014 indicated that nurses would document at least weekly on the appropriate wound progress form, either using the pressure ulcer documentation form or the skin injury progress form to track injuries not related to pressure. Under general preventative measures interventions include using devices that relieve pressure on the heels, using pillows and positioning devices to relieve	F 314		

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F 314	Continued From page 38 pressure and improve body alignment.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete timely assistance for toileting for 1 of 3 residents (R91) reviewed for urinary incontinence. Findings include: R91's admission Minimum Data Set (MDS), dated 9/26/14, identified R91 had severe cognitive impairment, was frequently incontinent of urine, and required extensive assistance of two staff to complete toileting. During continuous observation, starting on 11/20/14 at 1:42 p.m., R91 was lying in her room, in bed with her eyes closed. Nursing assistant (NA)-C entered the room at 2:10 p.m., and observed R91, however did not offer R91 to toilet before leaving the room. NA-C entered the room at 3:57 p.m. and offered to assist R91 with her	F 315	F315-D This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Lake Ridge Care Center to provide timely assistance with toileting for residents with urinary incontinence. 1. Regarding cited residents: The resident no longer resides at this facility. 2.Actions taken to identify other potential	12/22/14

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F 315	Continued From page 39 range of motion (ROM) exercises. NA-C offered to check R91 for incontinence at 4:03 p.m., and R91 had been incontinent of urine. NA-C had not offered help/assist R91 to toilet or with incontinence care for 2 hours and 21 minutes during the continuous observation. At 4:03 p.m., NA-C stated she had last assisted R91 with toileting or incontinence care at 1:00 p.m. (3 hours and 3 minutes) because of staffing. NA-C stated R91 should be checked for incontinence every two hours. Review of R91's Nursing Observations assessment, dated 9/26/14, indicated she was always incontinent of urine, and suffered from functional incontinence (caused by inability to get to the toilet per self or in a timely fashion). R91 required assistance with toileting, was unable to ask for toileting assistance, was unable to participate in a toileting program, and should be checked for incontinence and changed (if needed) every 2 hours. Review of R91's care plan, dated 10/9/14, identified she was incontinent of bowel and bladder, and was unaware of the need to void or defecate. The care plan lacked an indication for how often to assist her with incontinence care even though the assessment identified every two hours to assist with toileting//incontinence care. Review of R91's un-dated Resident Care Sheet indicated R91 was frequently incontinent of bowel and bladder, and should be, "C&C [checked and changed] Q [every] 2 hrs [hours]." When interviewed on 11/20/14 at 4:14 p.m., registered nurse (RN)-C stated the information listed on the Care Sheet(s) was accurate, and	F 315	residents having similar occurrences: Care plans for all residents have been reviewed and revised as needed, with appropriate interventions and timetables for staff to adequately provide for each of our resident s needs. 3.Measures put in place to ensure deficient practice does not recur: Care assignment sheets will reflect the reviewed and revised resident care plans so that residents can be toileted in a timely manner. 4.Effective implementation of actions will be monitored by: We will be directly observing toileting schedules and will be interviewing residents on scheduled toileting to confirm the care assignment sheets have properly reflected toileting in a timely manner. We will monitor two residents once per week in this fashion, and those findings will be placed on the 2014 POC Audit Form sheet. A summary of these direct observations and interviews will be submitted to the QAPI committee for two quarterly meetings. 5.Those responsible to maintain compliance will be: The Director of Nursing or designee is responsible to maintain compliance with timely assistance for toileting of residents. Completion date for certification purposes only is: December 22, 2014	

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F 315	Continued From page 40 staff should be checking R91 for incontinence every 2 hours. During interview on 11/20/14 at 4:21 p.m., RN-A stated R91 should be checked for, and assisted with incontinence care every 2 hours. When interviewed on 11/20/14 at 4:41 p.m., the director of nursing (DON) stated cares listed on the Care Sheet should be followed. A policy on toileting and incontinence care was requested, but none was provided.	F 315		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide nursing rehabilitative services for range of motion as ordered for 4 of 4 residents (R18, R66, R42, and R5) who received range of motion (ROM) through rehabilitative services to maintain or increase range of motion (ROM). Findings include:	F 318	F318-E This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law.	12/22/14

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F 318	Continued From page 41 R18's PPS 5 day assessment minimum data set (MDS) dated 11/11/14, indicated intact cognition, left sided weakness from residual affects of recent stroke, assistance of two persons for bed mobility, and assist of two persons for transfers from bed to wheelchair. R18's current care plan updated for activities of daily living (ADLS) 10/25/14 indicated he is at risk for ADLS decline related to recent stroke affecting left side and generalized weakness. Interventions in the care plan were one assist for grooming, dressing required 1-2 persons was to be monitored for changes in ADLS and a need for an occupational therapy evaluation. During observation of morning cares on 11/19/ 14 at 7:56 a.m., R18 required three persons to assist with bed mobility and transfers from bed to wheelchair. R18 did not not use arms or legs to assist in rolling necessary to complete incontinence care in bed including hygiene. At conclusion of morning cares NA-E stated [R18] was on a current restorative program for upper and lower body range of motion. "We do restorative with each of our group (group of residents in restorative program) ". NA-E moved 18's arms and legs in tandem while dressing R18. NA-E stated when we complete overhead movements to have clothing placed such as putting on a shirt this counts as a restorative program or other movements we do that are necessary to dress a resident. NA-B was also present during the observation, confirmed that dressing [R18] was sufficient as the restorative program for R18. NA-B stated there was no specific number of repetitions and it	F 318	It is the policy of Lake Ridge Care Center that nursing rehabilitative services are provided to maintain or increase range of motion (ROM). To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The residents cited have had their ROM programs adjusted to be provided more consistently to maintain or increase their ROM. 2.Actions taken to identify other potential residents having similar occurrences: All residents who have been reviewed that may benefit from a ROM program have had their ROM programs adjusted to be provided more consistently to maintain or increase their ROM. 3.Measures put in place to ensure deficient practice does not recur: A policy has been written regarding ROM programs. Nursing will identify all residents who may benefit from a ROM program on admission, as needed, upon discharge from therapy and on a quarterly basis. When a resident starts a ROM program, the care plan will be updated along with a 2014 POC Audit Form sheet. The nurse of the unit will monitor the ROM program for their residents and will be responsible to make sure that nursing assistants are completing the ROM programs per the goals of the care plan. Activities programming includes 3-5	

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F 318	Continued From page 42 is done to complete the task of dressing. We mark it as a completed range of motion restorative session in the restorative book. NA-E also showed the surveyor her LAKE RIDGE CARE CENTER RESIDENT CARE SHEET care performed with each resident for R18 it contained " active range of motion to (R18s) right side and passive range of motion to his left side ". The care sheet did not contain specific body parts, types of exercises listed for range of motion, or number of repetitions to be performed. During chart review active range of motion from 11/12 - 11/19/14 it was documented not performed 4 days out of 7 days in the electronic record point of click care. Passive range of motion charting was requested but not provided. During an interview on 11/19/2014 at 8:20 a.m.,, the director nursing (DON) stated, the nursing assistants that are assigned to each resident are responsible to document in point of care (electronic record for nursing staff to record resident treatments, medications and responses) and R18 should be receiving ROM as part of his morning cares. "If they are still on therapy caseload they would not receive restorative nursing." R18's last occupational treatment as he was discharged on 11/14/14 according to discharge shown by OTA-A. The nurses on the floor should be aware if R18 participated in a ROM program. NA's can guide them through dressing in the morning for activities of daily living (ADL) but this is not considered ROM. During an interview on 11/19/2014 at 12:31 p.m. with registered nurse (clinical coordinator for the unit) (RN-D), she stated if a resident had a restorative nursing program, the nursing	F 318	facility exercise programs weekly on a routine basis, which include exercises for both upper and lower extremities. Activities will update nursing if residents involved in these programs are no longer attending or actively participating so programs can be adjusted. 4.Effective implementation of actions will be monitored by: Monitored and completed 2014 POC Audit Form sheets will be collected by the Director of Nursing from the unit nurses on a weekly basis to insure completeness and proper procedures have been followed. A summary activity report of the ROM program compliance will be provided to the QAPI committee quarterly meeting for two quarters, and then as needed at the discretion of the QAPI committee. 5.Those responsible to maintain compliance will be: The Director of Nursing or designee will be responsible for maintaining compliance with nursing rehabilitative services for ROM. Completion date for certification purposes only is: December 22, 2014	

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assistant would be expected to move the body part 10-15 repetitions. Dressing does not count as ROM needs to be continuous repetitions.

During an interview on 11/20/14 at 9:41 a.m., with the physical therapist assistant (PTA)-A and occupational therapist assistant (OTA)-A stated, we hand off the restorative program to the clinical coordinator (RN in charge of the unit) and they put on care sheets and deal with it from there. If clinical coordinator has a concern or a question for a specific program they contact us again. Expectations are that a current restorative program for R18 would be daily, 7 x/week and performed by the nursing staff. If a program does not meet the staff or resident's needs then a therapy staff member would come up and work with the resident and nursing staff until all parties understand the program. "Repetitions in the range of motion (ROM) for (R18's) his ability would be the expectation for ROM and dressing alone should not suffice."

R18's restorative program signed and dated 11/17/14 was reviewed with PT-A the restorative program listed: left shoulder, and left fingers passive range of motion (the assistant guides the resident slowly through his joint mobility). Active range of motion (R18 moves the joint as far through the arc of motion without assist) R18 was to use seated exercises for his right leg and an arm bike for his right arm to maintain active range of motion. The PT-A stated staff that performed range of motion follow the ROM book for typical joint and muscle range of motion listed, 10- 15 repetitions would be the minimum range performed. Range of motion book lists at least 10 repetitions for ROM exercises to maintain joint mobility and lists specific exercises for each

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body part. OTA-A stated , R18 would lose range of motion and function, transfer ability and assistance with ADLS of ROM is not consistently completed. Dressing should not be used alone as a substitute for range of motion.

During an interview on 11/20/14 10:59 a.m., R 18 state, "I don't remember the last time they helped me with with stretching (range of motion) to my arms or legs like they did in therapies."

The facility has failed to provide R18 consistent range of motion as designated in the restorative nursing program.

R66's quarterly minimum data set (MDS) dated 9/30/14, included diagnoses of dementia, had severe cognitive impairment, no limitation in upper (UE) and lower extremity (LE).

R66's care plan dated 10/14/14, indicated she received a restorative nursing program, AROM (active range of motion) daily to promote the resident's ability to maintain or restore function to the highest level of physical functioning.

The RN (registered nurse) Restorative Nursing Monthly Review dated 10/28/14, indicated R66 was at risk for ADL decline related to diagnosis and condition. The Review indicated R66's AROM goal was met and to continue to comb own hair, apply makeup, and had some refusals due to medical condition in last 30 days but to continue plan of care.

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F 318	Continued From page 45 The facility had a Therapy Assessment -- 701 FORM Occupational Therapy form dated 7/22/14, indicated R66's Occupational Therapy (OT) was discontinued due to hospitalization with possible cellulitis to hand. The form identified "Res (resident) DC (discontinued) rx (treatment), dc to hosp with possible cellulitis to hand. At time of dc res was not participation with therapy refused last 2 sessions and needed max verbal and tactile cues to participate the other dates of service. She was able to propel wc short distances in SNF (skilled nursing facility) using LE (lower extremity) however did use UE (upper extremity) on occasion or when cued to do so." Although OT was discontinued on 7/22/14, the form did not identify if restorative nursing program was to be implemented or not. Review of the Restorative Nursing Program dated 2/14/14 which was recommended by physical therapy assist (PTA)-A indicated AROM program to UE (upper extremity) and LE (lower extremity) once a day. Review of Point of Care History indicated the following: September 2014-AROM completed 30 times out of 30 opportunities. October 2014- AROM completed 16 times out of 31 opportunities, deferred due to condition three times and not observed twice. The Point of Care History did not indicate why R66 did not receive AROM the remaining 10 opportunities. November 1st thru November 19th 2014- AROM completed 10 times out of 19 opportunities, the Point of Care History did not indicate why R66 did	F 318		

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F 318	Continued From page 46 not receive AROM the remaining 9 opportunities. During observation 11/19/14, at 12:00 p.m. R66 was observed to be in her wheelchair wheeling down the hall independently, there was no indication that R66 recieved her AROM excercise program. During interview 11/19/14, at 9:05 a.m. NA- D stated they are short staffed and she is unable to complete AROM on R66 a lot of the time due to not having enough time. During interview 11/20/14, at 11:25 a.m. OT-A stated she was not aware that R66 was not receiving her AROM according to her plan of care. OT-A further stated the clinical coordinators are supposed to let therapy know if residents are not completing there programs and they had not with R66. During observation 11/20/14, at 11:50 a.m. the OT-A was observed to provide AROM with R66 and stated the resident remained unchanged and that she still has full ROM. R42's quarterly MDS dated 9/16/14, indicated she was cognitively intact, had hypertension and anemia. The MDS further indicated she needed extensive assist of one with ADL's and had impairment on onside of her UE and no impairment on her LE. R42's CAA dated 4/15/14, indicated she needed assistance with all ADL's due to multiple diagnosis including arthritis. Has attended PT and OT in the past and was at her highest level of function, restorative program in place.	F 318		

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F 318	Continued From page 47 R42's care plan dated 10/21/14, indicated she received AROM to promote her ability to maintain or restore function to the highest level of physical functioning. The care plan indicated she needed AROM to UE and LE daily for 15 minutes may include seated leg exercises, thera-band, hand gripper or squeeze ball. The Therapy Assessment Occupational Therapy dated 09/06/13, completed by OT, indicated she received OT five times a week for 23 sessions and met goals with bilateral UE she has low motivation and no longer required OT services and was discontinued. R42 was to stay long term and participate on nursing restorative and walk program as tolerated. Restorative Nursing Program dated 10/19/11, indicated she was receive AROM to UE and LE 15 minutes daily. RN Restorative Nursing Monthly Review dated 10/21/14, indicated no need for OT referral and was to dress upper extremity with set up assist. The summary of of the goal indicated goal not appropriate. Staff assist with dressing change goal to a more appropriate one does continue to complete AROM program daily tolerates program fair to good. The summary also indicated she had no changes in her ROM voluntary movement since last review. The Point of Care History indicated the following: September 2014- AROM 29 out of 30 opportunities. The history indicated R42 received AROM several times at twice a day. October 2014- received AROM 12 out of 31	F 318		

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opportunities, no information was documented five times. No information was provided why R42 did not receive AROM the remaining 14 times.

November 2014- received AROM 19 out of 19 opportunities.

During interview 11/19/14, at 9:07 a.m. NA- B who verified R42 does not receive her AROM consistently and that she should and when they are short staffed it is impossible to get her work done.

R5's quarterly MDS dated 10/07/14, indicated she had seizure disorder and hypertension. The MDS further indicated she was cognitively intact and needed extensive assist of two with dressing, and assist with personal hygiene and had no impairment on her UE and LE. R5's care area assessment (CAA) dated 10/07/14, indicated she needed assistance with ADL's (activity of daily living) due to weakness related to osteoarthritis and is at her highest level of functioning.

R5's care plan dated 08/05/14, indicated she needs assist with dressing, bathing and grooming needs assist of one to two with all ADL's. The care plan indicated she received AROM.

Occupation Therapy note dated 10/26/11, indicated she received OT for limited UE ROM and fatigued easily with tasks. She participated in upper body dressing and maximum assist with LE dressing. The note further indicated for patient to resume restorative nursing program.

Restorative Nursing Program recommended by

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F 318	Continued From page 49 "therapies" dated 10/21/11, indicated she was to receive AROM to UE and LE for 15 minutes once a day. RN Restorative Nursing Monthly Review dated 10/21/14, indicated she had no changes in her ROM/voluntary movement and did not need a OT referral. The summary of her goal was to continue to dress upper half of body and use stand for transfers indicated she continues to complete AROM program with meeting goal. Has completed 27 out of 30 days. Tolerates fair to good, goal appropriate unable to progress to higher level continue to maintain current mobility with no decline. The Point of Care History indicated the following: September 2014- AROM occurred 15 minutes or greater 18 out of 30 opportunities, and refused 3 times. The history did not indicate why she did not receive AROM the remaining 12 times. October 2014- AROM 27 out of 31 opportunities and refused once. The history did not indicate why she did not receive ROM the remaining four days. November 1st thru November 19th 2014- AROM received for 15 minutes or more occurred 16 out of 19 opportunities. The history did not indicate why R5 did not receive AROM for 15 minutes or greater the remaining four opportunities. During interview 11/19/14, at 9:01 a.m. NA- D stated she was the only one working on her unit today for 13 residents and they should have two NA's on her unit. NA-D said this happens at least once a week and because of that the restorative	F 318		

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nursing programs can not get completed.

During interview 11/20/14, at 11:25 a.m. with PT-A stated the clinical coordinators were in charge of the restorative program and thought the DON oversaw the program also. PT-A stated the nursing staff are to inform us if a resident is not participating, has a decline or has an injury with a fall. They were not informed the restorative programs were not being completed as assessed.

During interview 11/20/14, at 12:05 p.m., the DON stated there have been some days where there just isn't enough staff to complete the restorative programs and there are days she is working on the floor and knows it just can not get done. The DON stated the nursing staff had been trained in the restorative programs and they do not have a facility specific policy but they follow the RAI (resident assessment instrument) manual.

During interview 11/20/14, at 1:50 p.m. with clinical coordinator registered nurse (RN)-D who stated the nursing assistance are to complete there restorative nursing and that she was not informed they were unable to complete there programs.

The facility provided training 4/01/14 and 4/2/14 for the nurses and nursing assistance, on Restorative Nursing Programs. The training materials indicated "Each resident who is on a restorative nursing program has been assessed by the nurse and found to be appropriate and able to do the programs listed on the restorative program found in your care books behind the personal data sheet. Any information about the

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F 318	Continued From page 51 program including what programs and how often to do them can be found there and the Clinical Coordinator can answer any questions you may have about the program or address it if you find the resident is unable or unwilling to follow the program. Once you have been educated on the program for your resident, please sign/date at the bottom of the sheet. You are required to follow the restorative nursing programs for our residents to be in compliance with their plan of care - so you do have an obligation here!".	F 318		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced	F 353		12/22/14

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F 353	Continued From page 52 by: Based on observation, interview and document review, the facility failed to allocated staff in sufficient numbers to ensure care was provided to 8 of 15 residents (R66, R73, R42, R5, R18, R91, R121 and R22) reviewed for personal cares. In addition, for 2 of 2 family members (FM)-B, and FM-A) and 6 of 10 employees (trained medication assistant) TMA-A, licensed practical nurse (LPN)-B, nursing assistant (NA)-D, NA-B, registered nurse (RN)-C and NA-C, who had, and expressed concerns about resident cares not being completed, or completed timely due to insufficient staffing. Findings include: Care not provided to residents: The facility failed to provide and consistently implement restorative ambulation services to improve and/or maintain the resident's ambulation ability for 3 of 4 residents (R66, R73 and R42) in the sample reviewed for ambulation. Refer to F311 for further information. The facility failed to provide nursing rehabilitative services as ordered for 4 of 4 residents (R18. R66,R42, and R5) reviewed for rehabilitative services to maintain or increase range of motion (ROM). Refer to F318 for further information. The facility failed to complete timely assistance for toileting for 1 of 3 residents (R91) reviewed for urinary incontinence. Refer to F315 for more information.	F 353	F353-E This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Lake Ridge Care Center to allocate employees in sufficient numbers to provide the care necessary for the needs of our residents. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: We have provided written plans of correction for F-tags 279, 311, 312, 315 and 318 relating to the care of these cited residents found in the findings of our most recent CMS-2567, and how we have and/or will address those respective issues. We will continue interview, select and train prospective nursing employees as they are available to provide the care needed to these cited residents. 2.Actions taken to identify other potential residents having similar occurrences: We have provided written plans of correction for F-tags 279, 311, 312, 315 and 318 relating to the care of our residents, and how we have and/or will address those potential issues. We will	

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F 353	Continued From page 53 The facility failed to provide routine bathing for 2 of 3 residents (R121 and R22) who were dependent upon staff for activities of daily living. Refer to F312 for further information. The facility failed to consistently implement cared-planned interventions for restorative nursing, oral care, incontinence care and fall/accident prevention for 7 of 33 residents (R66,R73,R42,R5,R18,R121,R22) in the sample reviewed for care plan implementation. Refer to F282 for additional information. Complaints expressed by residents and families: R22's quarterly MDS, dated 10/28/2014, indicated intact cognition, and that she required extensive assistance for transferring, bed mobility and most ADLs. R22 stated "Right now, there is really not enough staff available to help." R22 also said it can take up to an hour to wait for someone to assist, and "that's no kidding." R124's admission MDS, dated 8/29/2014, indicated she required staff assistance with bed mobility and transferring, and also that R124 had intact cognition. R124 stated "the staff do a wonderful job" and added that the facility is just "under-staffed." R124 said the staff "just can't keep up." R55's quarterly MDS, dated 11/4/2014, indicated intact cognition, and further that he required extensive assistance with bed mobility, transfers, dressing, and toileting. R55 said that "staff have admitted to me they are short staffed." R55 also	F 353	continue interview, select and train prospective nursing employees as they are available to provide the care needed by our residents. 3.Measures put in place to ensure deficient practice does not recur: Nursing schedules are posted for two-week time periods, and any vacant positions are posted next to the schedule. These vacant hours are available to current employees, and are also called in to at least one pool agency if they cannot be filled before the pay period begins. Bonuses have been and will continue to be offered to fill vacant shifts. Advertisements for nurses and nursing assistants have been and will continue to be placed in local papers until any open positions are filled. Locations that provide nursing assistant programs have been contacted to let them know of any open positions. Any potential applicants will be contacted at our earliest convenience to arrange interviews, and selection of new employees will be done within the requirements of employment law. To allow for the proper care of our residents, we have also added on a part-time nursing assistant to specifically be bath aide. 4.Effective implementation of actions will be monitored by: Open positions and vacant shifts will be recorded on the schedule and an explanation of how those open positions or vacant shifts were covered will be written in the Shift Coverage book. If a	

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said he has sometimes waited 30 minutes or longer just to answer the call light, often times "hollering out for them to come and help." R55 stated if he yells, he's afraid he may "wake up the rest of the residents." R55 added, that staff have told me "to use my call light," and then I tell staff "they don't answer my light." R55 said "staff have told me 'I have other people to take care of, too.'"

R31's quarterly MDS, dated 9/3/2014, indicated intact cognition, and that she required extensive assistance with most ADLs, and was totally dependent upon staff for bathing. R31 stated, that it's not the staff's fault, but sometimes" I have had to wait for an hour when I need to go to the bathroom, or bed." R31 said she has had both bowel and bladder "accidents."

R64's quarterly MDS, dated 9/16/2014, indicated intact cognition, and that she required staff assistance for bed mobility, transfers, dressing and toileting. In an interview, R64 stated "They do not have enough staff here." R64 said it was frustrating when staff would say "I will be back, and then they leave my room, and don't come back."

R128's MDS, dated 10/27/2014, indicated she had intact cognition. Further, the MDS indicated she required staff assistance for dressing, toileting, personal hygiene, transferring and bed mobility. R128 said she was a morning person, and she often had to wait for help, especially in the morning. R128 said "I put my call light on, and I wait. I think they need more help."

During an interview on 11/17/2014 at 2:48 p.m., family member (FM)-B stated he has been told "not to assist [R82] into he bathroom" but says "I

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shift cannot be filled for some reason, the Director of Nursing will be contacted, and that contact, time and vacancy will be written in the Shift Coverage Book. The Director of Nursing will inform the Administrator weekly for two months of open nursing department positions and shifts unable to be filled and the course of action to fill those positions and shifts, and as needed thereafter. The Director of Nursing will report summarized Shift Coverage book data to the QAPI committee for two quarters, or as needed until all open positions are filled.

5.Those responsible to maintain compliance will be:
The Director of Nursing or designee is responsible for allocating nursing employees in sufficient numbers to care for our residents.

Completion date for certification purposes only is: December 22, 2014

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do it anyway." FM-B said his mother could not wait long enough for staff to assist her, before she soils herself. FM-B said "I do not expect one to one assistance for all the patients, but FM-B emphasized the number of staff available to assist with his mother's needs, and other patients, "was not enough." FM-B stated he sensed his mother often wait for help and that he was concerned, "especially when I am not here to help her."

During an interview on 11/18/2014 at 4:29 p.m., family member (FM)-A stated [R138] has had to wait for toileting help "many times," and often more than 10 minutes. FM-A said "[R138] cannot hold it that long, and he has been incontinent." FM-A said "It's not the girls' fault, they just need more persons." FM-A said her son has "often helped" [R138] on the toilet, "and 10 minutes later, after we put the call light on, a nurse shows up."

Complaints expressed by staff:

During interview 11/18/2014, at 7:35 p.m. trained medical assistant (TMA)-A stated "I pass meds and I also get pulled to the floor when they are short staffed, we have had staffing issues lately because a lot of our staff have left, and I don't know why."

During interview 11/19/2014, at 7:44 a.m. licensed practical nurse (LPN)-B stated "staffing here is awful we have no on-call nurses to fill in the open shifts. If the nursing assistance are

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short I help get the residents up, I struggle to get my charting done, call lights are going off all of the time and we cant answer them timely."

During interview 11/19/2014, at 9:01 a.m. nursing assistant (NAR)-D stated she is the only the one working on her unit. I have 13 residents and after 12:00 p.m. we will be down two aides in the building this seems to happen at least once a week. I cant get my walks and charting done if you look at the logs you can see that. We are just so short staffed baths are not always getting done and there are many blanks on the bath sheets. I also cant get my restorative rehab nursing done and its frustrating."

During interview on 11/19/2014, at 12:04 p.m. interview with NAR-B who stated I work full time day shift and feels the staffing here is terrible, we are short staffed and It seems like we are short staffed every day and at times we cant get our restorative nursing completed. In a subsequent interview on 11/20/2014 at 9:24 a.m., NAR-B stated the restorative nursing programs were to be run 7 days a week, and that she "usually" got her walks done, but that "the range of motion (ROM) programs do not get done."

During interview 11/20/2014, at 12:00 p.m. with the administrator who stated the staffing is challenging right now and it is harder to find staff we have ads in the paper and currently have two staff on a family medical leave act (FMLA) I am having the managers help out on the floor and stay late to help. The administrator further stated they are utilizing a staffing agency but they have few staff they can send to us also. He also stated

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F 353	Continued From page 57 the facility has an older call light system and that it is not digital so they can't run reports to see how long call lights are left on for and that they do not conduct random audits with the current call light system to see how long it is taking staff to answer the lights. The administrator stated they do not have a policy on staffing for the building. During interview 11/20/14, at 2:18 p.m. registered nurse (RN)-D stated she is not working as a clinical coordinator and she had been pulled to the floor today because they do not have enough staff on the floor. The RN-D stated she works on the floor once every two weeks and was not aware the restorative nursing programs were not getting done and the staff should have informed her. During interview 11/20/14, at 3:57 p.m. NA-C stated she is the only one working on her unit today and that she had informed the DON of her concern of not having enough staff and the DON told me "it needs to be done". She then stated if there was enough staff she would be able to toilet the residents appropriately within the needed times and she further stated they don't check the residents at night for being wet they just put the bigger green pads on them at night. NA-C added that "there are nurses who will not answer call lights." NA-C also said there were "many people who start out that just don't work out and that "the job is not the right fit for them." "It's hard to find and keep good people for this job."	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:	F 356		12/15/14

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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) COMPLETION DATE
F 356	Continued From page 58 o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to display the actual hours worked for all nursing staff on the daily staff posting. This had the potential to affect all 54 residents, staff, and any visitors who may wish to review this information. Findings include:	F 356	F356-C This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet	

POC NOT FINAL

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 ______	11/20/2014

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

(X4) ID 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 356

Continued From page 59

During the initial tour of the facility, on 11/17/14, at 9:10 a.m. a Lake Ridge Care Center - Nursing Department form was displayed in the commons area of the building. The posting indicated disciplines of registered nurses (RN), licensed practical nurses (LPN), trained medication aides (TMA), and nursing assistant, registered (NA/R), along with each disciplines total hours worked. The posting did included Day shift and NOC (night shift) with no designated start and end times for each shift. The posting also did not identify the actual hours worked by these disciplines.

During interview on 11/18/14, at 7:41 p.m. with director of nursing (DON) stated the staff work 12 hour shifts from 6:00 a.m. to 6:00 p.m. and 6:00 p.m. to 6:00 a.m. and they have a short shift on p.m.'s from 6:00 p.m. to 10 p.m. The DON stated she was not aware the actual hours needed to be listed on the staff posting.

During interview on 11/18/14, at 7:50 p.m. with the administrator who stated the form must have been changed in the computer because the form does not automatically change the date at the top of the form. The administrator further stated he was not sure if the form's indicated the actual hours in the past but they do not now.

A facility policy on the staff posting was requested, but none was provided.

F 356

requirements established by State and Federal law.

It is the policy of Lake Ridge Care Center that nursing hours will be posted on a daily basis.

To assure continued compliance, the following plan has been put into place;

1. Regarding cited residents:
There were no residents cited regarding in this deficiency.

2.Actions taken to identify other potential residents having similar occurrences:
There are no other residents having similar occurrences as none can be identified.

3.Measures put in place to ensure deficient practice does not recur:
Nursing hours will be posted on a daily basis by the nursing department and will be tracked on a checklist. A policy has also been created for the posting of nursing hours.

4.Effective implementation of actions will be monitored by:
The charge nurse will use a checklist to track the posting of nursing hours daily. These checklists will be collected and monitored, and their findings reported to the QAPI committee for two quarters by the Director of Nursing or designee.

5.Those responsible to maintain compliance will be:

POC NOT FINAL

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	245513	A. BUILDING ______ B. WING ______	11/20/2014

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

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F 356	Continued From page 60	F 356	The Director of Nursing or designee will maintain compliance with the posting of nursing hours. Completion date for certification purposes only is: December 15, 2014	

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

F5513023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245513	A. BUILDING **01** B. WING	**11/18/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on November, 18, 2014. At the time of this survey, Building 01 of Lake Ridge Care Center was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145 Facsimile: 651-215-0525, or	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 12/19/2014

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245513	A. BUILDING **01** B. WING ______	**11/18/2014**

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

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Lake Ridge Care Center is a 2-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(111) construction. In 1976, an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The 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 fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 63 beds and had a census of 57 at time of the survey.	K 000		

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	245513	A. BUILDING 01 B. WING ______	11/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY STANDARD - Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment	K 018	K018-E It is the intention of Lake Ridge Care Center to insure that all doors are not impeded from closing. The door to resident room #111 was adjusted to correctly close and is no longer impeded from closing and latching into its frame.	12/15/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245513	A. BUILDING **01** B. WING ______	**11/18/2014**

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K 018	Continued From page 3 to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. NFPA 101 (00), Chapter 19, Section 19.3.6.3. This STANDARD is not met as evidenced by: Based upon observation, the facility had a corridor door which was impeded from fully closing and latching into its frame. In a fire emergency, this deficient practice could adversely affect 20 of 57 residents, staff and visitors. FINDINGS INCLUDE: On 11/18/2014 at 10:00am, observation revealed the corridor door to Resident Room 111 was impeded from closing and latching into its frame. This deficient practice was verified by the Enviromental Services Director.	K 018	The Environmental Director will continue to insure doors are not impeded from fully closing. Completion date for certification purposes only is: December 15, 2014.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-2.1.1 and 2-2.2. This deficient practice could affect all 57 out 57	K 062	K062-D It is the intention of Lake Ridge Care Center to maintain our automatic sprinkler system in reliable operating condition. The sprinkler heads in the kitchen and	12/19/14

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	245513	A. BUILDING **01** B. WING ______	**11/18/2014**

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K 062	Continued From page 4 residents. Findings include: On facility tour between 8:45 am and 11:30 pm on 11/18/2014, observation revealed that the following were found: 1. Kitchen- Dishwashing area, Walk in freezer and cololer, the fire sprinkler heads located in this area were corroded. This deficient practice was verified by the Enviromental Services Director.	K 062	dishwashing area were dusted and cleaned to insure that they remained in reliable operating condition. The sprinkler heads in the freezer and cooler were replaced as they showed signs of build-up and were beginning to corrode. We have added the cleaning/dusting of sprinkler heads to our preventative maintenance program to be completed two times per year, or as necessary. The Environmental Director will monitor the sprinkler heads for continued reliability in operation. Completion date for certification purposes only is: December 19, 2014.	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Observations revealed that some electrical installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition. This deficiency could negatively effect any resident, staff and visitors in this area of the facility. Findings include: On facility tour between the hours of 9:00 amand 11:30 AM on 11/18/2014, observations revealed that the Therapy Office had a refrigerator plugged into electrical power strip. Also the use of multi-plug adapter were observed in the Therapy	K 147	K147-E It is the intention of Lake Ridge Care Center to provide electrical installations in accordance with NFPA 70. The power strip that was used in the Therapy office was removed and the refrigerator is now plugged directly into an outlet. The multi-plug adapters were removed in both the Therapy office and the Pine Room. The Environmental Director will continue	11/24/14

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	245513	A. BUILDING 01 B. WING ______	11/18/2014

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K 147	Continued From page 5 office and Pine room. This deficient practice was verified by the Enviromental Services Director.	K 147	to monitor for the proper use of electrical installations. Completion date for certification purposes only is: November 24, 2014.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245513	A. BUILDING **02 - OASIS** B. WING ______	**11/18/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey,Lake Ridge Care Center, Oasis wing (2014 addition) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Lake Ridge Care Center Oasis Wing is a 1-story building built in 2014 and was determined to be of Type 11 (111) construction. The building is fully sprinkled protected throughout. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 63 beds and had a census of 57 at	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/19/2014

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K 000	Continued From page 1 the time of the survey.	K 000		