#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					ND TRANSMITTAL E SURVEY AGENCY	ID: GGOI Facility ID: 00714
1. MEDICARE/MEDICAID PROVIDER N           (L1)         245513           2.STATE VENDOR OR MEDICAID NO.           (L2)         066663700	0.	3. NAME AND ADI (L3) LAKE RIDG (L4) 310 LAKE B( (L5) BUFFALO, M	E CARE CENTEI OULEVARD		(L6) <b>55313</b>	4. TYPE OF ACTION:     7 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9) 02/01/2004	NERSHIP	7. PROVIDER/SUF 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	<ol> <li>7. On-Site Visit</li> <li>9. Other</li> <li>8. Full Survey After Complaint</li> </ol>
<ul> <li>6. DATE OF SURVEY 01/8/2</li> <li>8. ACCREDITATION STATUS:</li> <li>0 Unaccredited 1 TJC 2 AOA 3 Other</li> </ul>	2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 01/31
<ul> <li>11LTC PERIOD OF CERTIFICATION</li> <li>From (a): To (b):</li> <li>12. Total Facility Beds</li> <li>13. Total Certified Beds</li> <li>14. LTC CERTIFIED BED BREAKDOWN</li> </ul>	63 (L18) 63 (L17)	B. Not in Com Requireme	ce With quirements Based On: .cceptable POC pliance with Program mts and/or Applied W	'aivers:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A* 15. FACILITY MEETS	6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room (L12)
18 SNF 18/19 SNF 63 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARK 17. SURVEYOR SIGNATURE Brenda Fischer, Ut	nit Superviso	Date : pr (	01/08/2015	(L19) GIONAI	18. STATE SURVEY AGENCY AP Kate JohnsTon, Enfo	orcement Specialist 01/29/2015 (L20)
19. DETERMINATION OF ELIGIBILITY        1. Facility is Eligible to Par        2. Facility is not Eligible			IPLIANCE WITH CI ITS ACT:	VIL	<ol> <li>Statement of Financ</li> <li>Ownership/Control</li> <li>Both of the Above :</li> </ol>	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 02/01/1988 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEMI BEGINNING I (L41) 27. ALTERNATIVI	DATE E SANCTIONS	4. LTC AGREEMEN ENDING DATE (L25)		26. TERMINATION ACTION:         VOLUNTARY       00         01-Merger, Closure         02-Dissatisfaction W/ Reimburseme         03-Risk of Involuntary Termination         04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety
(L27)	A. Suspension o		(L44) (L45)			00-Active
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C 03001	ARRIER NO.	(L31)	<sup>30. REMARKS</sup> Posted 01/29/2015 C	
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION 0 01/08/2015	OF APPROVAL DAT	E (L33)	DETERMINATION APPRO	VAL



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



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 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

Minnesota Department of Health • Health Regulation Division General Information: 651-201-5000 • Toll-free: 888-345-0823 http://www.health.state.mn.us An equal opportunity employer



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

Minnesota Department of Health • Compliance Monitoring General Information: 651-201-5000 • Toll-free: 888-345-0823 http://www.health.state.mn.us *An equal opportunity employer* 

#### **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 245513	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 1/8/2015
Name	of Facility		Street Address, City, State, Zip Code	
LAI	KE RIDGE CARE CENTER OF BUFFALC	)	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	(Y4)	Item		(Y5)	Date	(Y4)	ltem		(Y5)	Date
				Correction					Correction					Correction
10	Durfu	50070		Completed			50000		Completed		ID Desfer	50044		Completed
		F0279		12/22/2014		ID Prefix			12/22/2014		ID Prefix			12/22/2014
	Reg. # LSC	483.20(d), 483.20	(k)(1)			Reg. # LSC	483.20(k)(3)(ii)				Reg. # LSC	483.25(a)(2)		
	100					200					200			
				Correction					Correction					Correction
				Completed					Completed					Completed
ID	Prefix	F0312		12/22/2014		ID Prefix	F0314		12/22/2014		ID Prefix	F0315		12/22/2014
	0	483.25(a)(3)					483.25(c)				0	483.25(d)		
	LSC					LSC					LSC			
				Correction					Correction					Correction
				Completed					Completed					Completed
ID	Prefix	F0318		12/22/2014		ID Prefix	F0353		12/29/2014		ID Prefix	F0356		12/15/2014
	Reg. #	483.25(e)(2)				Reg. #	483.30(a)				Reg. #	483.30(e)		
	LSC					LSC					LSC			
				Correction					Correction					Correction
ID	Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
	Reg. #			-		Reg. #								
	LSC			-							LSC			
				Correction					Correction					Correction
ID	Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
	Reg. #					Reg. #								
	LSC					LSC					LSC			
Revie	wed By	/ R	eviewed E	Зу	Da	ite:	Signature o	f Surve	yor:				Date:	
State	Agency	<b>y</b>	BF	/KJ	1	/21/201	.5		34764				1/8/2	2015
Revie	wed By	/ R	eviewed E	Зу	Da	ite:	Signature o	f Surve	yor:				Date:	
CMS	RO													
Follo	wup to	Survey Complete	d on:					-				a Summary of		
		11/20/2	014				Unc	orrecte	d Deficiencies	s (CMS	6-2567) Sent	to the Facility?	YES	NO

#### **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 245513	<b>(Y2) Multiple Constru</b> A. Building B. Wing	N BUILDING 01	(Y3) Date of Revisit 12/24/2014
Name	of Facility		Street Address, City, State, Zip Code	
LA	KE RIDGE CARE CENTER OF BUFFALC	)	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	(Y4)	Item		(Y5)	Date	(Y4)	ltem		(Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			12/15/2014		ID Prefix			12/19/2014		ID Prefix			11/24/2014
-	NFPA 101				-	NFPA 101				-	NFPA 101		
LSC	K0018				LSC	K0062				LSC	K0147		
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #			-		Reg. #			
									+-				
			Correction					Correction					Correction
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Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix			-		ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			
Reviewed By	y F	Reviewed E	Зу	Da	te:	Signature o	f Surve	yor:				Date:	
State Agenc	у	PS/k	KJ	1/	/21/201	5	34	1764				12/24	4/2014
Reviewed By	y F	Reviewed E	Зу	Da	te:	Signature o	f Surve	yor:				Date:	
CMS RO													
Followup to	Survey Complet	ed on:				Check	for any	Uncorrected	Deficie	ncies. Was	a Summary of		
	11/18/2	2014				Unc	orrecte	d Deficiencies	s (CMS	-2567) Sent	to the Facility?	YES	NO

DEPARTMENT OF HEALTH A	ND HUMAN SEI	RVICES				CEN	NTERS FOR	MEDICARE & M	EDICAID SE	RVICES
	MED	ICARE/MEDICA	AID CERTIFIC	ATION A	ND TRAN	ISMIT	TAL		ID: GGOI	
	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVE	YAGE	ENCY	1	Facility ID: 0	0714
1. MEDICARE/MEDICAID PROVIDER N           (L1)         245513           2.STATE VENDOR OR MEDICAID NO.         (L2)           066663700         066663700	iO.	3. NAME AND ADI (L3) LAKE R (L4) 310 LAK (L5) BUFFAL	IDGE CAR E BOULEV	E CENT		BUF (L6)	FALO 55313	<ol> <li>TYPE OF ACTI</li> <li>Initial</li> <li>Termination</li> <li>Validation</li> </ol>	2. Recer 4. CHO 6. Comp	tification W
5. EFFECTIVE DATE CHANGE OF OW	NERSHIP	7. PROVIDER/SUP			02	(L7)		7. On-Site Visit 8. Full Survey Aft	9. Other ter Complaint	
(L9) 02/01/2004	0/0014 (124)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESRD 10 NF	13 PTIP		22 CLIA			
6. DATE OF SURVEY 11/2 8. ACCREDITATION STATUS:	20/2014 (L34) (L10)	02 SNF/NF/Duai 03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	14 CORF 15 ASC			FISCAL YEAR END	DING DATE:	(L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSP	ICE		01/31		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:							
From (a):		A. In Complian	ce With		And/Or	Approve	ed Waivers Of The	Following Requirement	ts:	
To (b) :		Program Re Compliance	1				ical Personnel	6. Scope of		
12. Total Facility Beds	<b>63</b> (L18)	-	cceptable POC			. 24 Ho . 7-Day	our RN 7 RN (Rural SNF)	7. Medical I 8. Patient Re		
· · · · · · · · · · · · · · · · · · ·	00 (=)						Safety Code	9. Beds/Roo		
13.Total Certified Beds	<b>63</b> (L17)		pliance with Program ents and/or Applied V		* Code:	1	B*	(L12)		
14. LTC CERTIFIED BED BREAKDOWN	I				15. FACILI	TY ME	ETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e)	(1) or 18	861 (j) (1):	(L15)		
63										
(L37) (L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGENCY REMARK	KS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):							
17. SURVEYOR SIGNATURE		Date :			18. STATI	E SURV	EY AGENCY AP	PROVAL	Date:	
Carol Bode	HFE NE II		01/05/2015	(L19)	<u>Kate</u> ]	[ohn	<u>sTon, Enf</u>	forcement Sp	01 ecialist	/07/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE	OR SI	INGLE STAT	E AGENCY		
19. DETERMINATION OF ELIGIBILITY			PLIANCE WITH C	IVIL	21.	2. Ov	wnership/Control I	al Solvency (HCFA-2572 nterest Disclosure Stmt (	/	
1. Facility is Eligible to Par     2. Facility is not Eligible	ncipate					3. Bo	oth of the Above :			
2. Turing is not singlote	(L21)									
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	NT	26. TERM	MINATI	ON ACTION:		(L30)	
OF PARTICIPATION <b>02/01/1988</b>	BEGINNING	DATE	ENDING DATE	Ξ	<u>VOLUNT</u> 01-Merger		00		<u>LUNTARY</u> to Meet Health/Sa	fety
(L24)	(L41)		(L25)		02-Dissatis	sfaction	W/ Reimbursemer	nt 06-Fail	to Meet Agreemer	nt
25. LTC EXTENSION DATE:	27. ALTERNATIVI	E SANCTIONS			03-Risk of	Involunt	ary Termination	OTHE	<u>R</u>	
	A. Suspension of	of Admissions:			04-Other R	eason fo	or Withdrawal	07-Pro	vider Status Chang	ge
(L27)	D.D 10		(L44)					00-Act	ive	
	B. Rescind Sus	pension Date:	(L45)							
28. TERMINATION DATE:	20	INTERMEDIARY/C			30. REMA	BKC				
20. TERMINATION DATE.	29		AARIEN NU.		JU. KENIA	uuro				
	(L28)	03001		(L31)	Po	sted	01/08/20	15 Co.		
31. RO RECEIPT OF CMS-1539	32	DETERMINATION C	OF APPROVAL DAT	ΓE						

(L33)

DETERMINATION APPROVAL

(L32)

-

-



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

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

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

# 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.

Lake Ridge Care Center Of Buffalo December 9, 2014 Page 4

## 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 Lake Ridge Care Center Of Buffalo December 9, 2014 Page 5

> 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

ate Comston

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

		AND HUMAN SERVICES			RINTED: 12/29/2014 FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PROVIDER OR SUPPLIER	245513 OF BUFFALO	3	STREET ADDRESS, CITY, STATE, ZIP CODE STO LAKE BOULEVARD BUFFALO, MN 55313	11/20/201 <u>4</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 000 F 279 SS=D	as your allegation of Department's accelenrolled in ePOC, at the bottom of the form. Your electro be used as verifical Upon receipt of an on-site revisit of yovalidate that substaregulations has be your verification. 483.20(d), 483.20( COMPREHENSIVE A facility must use to develop, review comprehensive plat The facility must de plan for each resid objectives and time medical, nursing, a needs that are ider assessment. The care plan must to be furnished to a	of correction (POC) will serve of compliance upon the optance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with k)(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's in of care. evelop a comprehensive care ent that includes measurable etables to meet a resident's and mental and psychosocial ntified in the comprehensive t describe the services that are attain or maintain the resident's	F 000 F 279		12/22/14
LABORATOR	psychosocial well-ł §483.25; and any s be required under due to the resident §483.10, including under §483.10(b)(4	physical, mental, and being as required under services that would otherwise §483.25 but are not provided 's exercise of rights under the right to refuse treatment 4).	NATURE	TITLE	(X6) DATE
Electron	ically Signed				12/19/201

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.

	-	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			RM APPROVE NO. 0938-039
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION (X3)	DATE SURVEY
		245513	B. WING		11/20/2014
NAME OF I	PROVIDER OR SUPPLI	ER	5	STREET ADDRESS, CITY, STATE, ZIP CODE	
				310 LAKE BOULEVARD	
LAKE RI	DGE CARE CENTE	ER OF BUFFALO	1	BUFFALO, MN 55313	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 279	Continued From	page 1	F 279		
		IENT is not met as evidenced			
	by: Based on obser	vation, interview, and document		F279-D	
		ty failed to develop a		This Plan of Correction constitutes my	
		care plan to include a toileting		written allegation of compliance for the	
		3 residents (R91) reviewed for		deficiencies cited. However, submission	n
	urinary incontine	nce.		of this Plan of Correction is not an	
	Findings include			admission that a deficiency exists or that	at
	Findings include			one was cited correctly. The Plan of Correction is submitted to meet	
	R91's admission	Minimum Data Set (MDS), dated		requirements established by State and	
		d R91 had severe cognitive		Federal law.	
		frequently incontinent of urine,			
		ensive assistance of two staff to		It is the policy of Lake Ridge Care Cent	
	complete toiletin	g.		to develop comprehensive care plans for	or
	Deview of DOMs			toileting programs related to urinary	
		Nursing Observations ed 9/26/14, indicated she was		incontinence.	
		nt of urine, and suffered from		To assure continued compliance, the	
		inence (caused by inability to get		following plan has been put into place;	
		self or in a timely fashion). R91			
		nce with toileting, was unable to		1. Regarding cited residents:	
		assistance, was unable to		The cited resident is no longer at this	
		pileting program, and should be		facility.	
		ntinence and changed (if		2 Actions taken to identify other notanti	
	needed) every 2	nours.		2.Actions taken to identify other potentia residents having similar occurrences:	ai
	R91's care plan	dated 10/9/14, identified R91		Care plans and care assignments have	
		of bowel and bladder, and was		been reviewed and revised to meet the	
		need to void or defecate. The		needs of residents who have urinary	
		t identify a toileting program, nor		incontinence.	
		ist R91 to the toilet or provide		2 Magguros put in place to ensure	
	incontinence car	E.		3.Measures put in place to ensure deficient practice does not recur:	
	During continous	s observation, starting on		Toileting programs have been and will b	be
		p.m., R91 was lying in her room,		assessed at admission, return from	-
		yes closed. Nursing assistant		hospital, quarterly and with each chang	е
		he room at 2:10 p.m., and		of condition. The Director of Nursing of	

Facility ID: 00714

STATEMEN	T OF DEFICIENCIES DF CORRECTION	RE & MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:	(X2) MULTIPL		(X3) DATI	0938-039 SURVEY PLETED
	PROVIDER OR SUPPLIE		31	TREET ADDRESS, CITY, STATE, ZIP COI 10 LAKE BOULEVARD UFFALO, MN 55313		20/201 <u>4</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 279	observed R91, he incontinence or to NA-C entered the to assist R91 with exercises. NA-C incontinence at 4 incontinent of urin 4:03 p.m., NA-C assisted with toile 1:00 p.m. (3 hour because of being should be offered every 2 hours. N care plan did not with incontinence When interviewe registered nurse checked for incon R91's care plan I often R91 should incontinence care During interview stated R91 had b facility from being infection and sho incontinence care identifed in the care When interviewe director of nursin should identify he including R91, to incontinence care	by ver did not assist R91 with bileting before leaving the room. a room at 3:57 p.m. and offered h her range of motion (ROM) offered to check R91 for :03 p.m., and R91 had been he, 2 hours and 21 minutes. At stated R91 had not been eting or incontinence care since 's and 3 minutes) that afternoon a short staffed. NA-C stated R91 d the toilet/incontinence care A-C was unaware what R91's identify how often to assist her a care. d on 11/20/14 at 4:14 p.m., (RN)-C stated R91 should be ntinence every 2 hours; however acked any guidance on how be assisted with toileting or e. on 11/20/14 at 4:21 p.m., RN-A eeen recently re-admitted to the g hospitalized for a urinary tract uld be checked or assisted with e every 2 hours, but this was not are plan for R91. d on 11/20/14 at 4:41 p.m., the g (DON) stated the care plan ow often to help a resident, the toilet or complete e.	F 279	<ul> <li>designee will perform weekly, audits of care plans for toiletin related to urinary incontinence Re-education was completed clinical management team on individualized care plans regatoileting needs.</li> <li>4.Effective implementation of be monitored by: The Director of Nursing or de choose at random two care p week and will review for compappropriately assessed toiletif for three months, and one car week for an additional three m summary of that compliance submitted to the QAPI commit quarterly meetings.</li> <li>5.Those responsible to maint compliance will be: The Director of Nursing or de responsible for maintaining cardeveloping comprehensive cardioleting programs related to the incontinence.</li> <li>Completion date for certificationly is: December 22, 2014</li> </ul>	ng programs e. with the developing arding actions will signee will lans per oliance ng programs re plan per nonths. A will be ttee for two ain signee is ompliance in are plans for urinary on purposes	

If continuation sheet Page 3 of 61

CENTER STATEMENT	S FOR MEDICAL	TH AND HUMAN SERVICES RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	FORM OMB NO	: 12/29/201 APPROVEI . 0938-039 E SURVEY
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING		1PLETED 20/2014
	PROVIDER OR SUPPLIE		3	STREET ADDRESS, CITY, STATE, ZIP CODE STO LAKE BOULEVARD BUFFALO, MN 55313	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 282 F 282 SS=E	483.20(k)(3)(ii) S	ERVICES BY QUALIFIED	F 282 F 282		12/22/14
	must be provided	vided or arranged by the facility I by qualified persons in each resident's written plan of			
	by: Based on observ review the facility care planned inten nursing, and ski residents (R121, R18) in the samp implementation. Findings include: BATHING			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.	
	9/17/14, indicated needed limited as bathing and groo 10/15/14, indicated	n minimum data set (MDS) dated d she was cognitively intact and ssist of one with dressing, ming. R121's care plan dated ed she needs assist with all of daily living) and assist of one g.		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;	
	assistant (NA)- D staffed and baths done as they are bath sheets whic signed off as give	11/19/14, at 9:01 a.m. nursing stated the facility is short and showers are not getting scheduled. NA-D provided the h indicated R121's bath was not en. NA-D stated we "were affed and the bath didn't get		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	

Facility ID: 00714

If continuation sheet Page 4 of 61

		TH AND HUMAN SERVICES <u>RE &amp; MEDICAID SERVICES</u>			OMB NO.	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
		245513	B. WING		11/2	20/2014
NAME OF F	PROVIDER OR SUPPLIE	R	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTE	R OF BUFFALO	-	10 LAKE BOULEVARD		
			В	UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 282	Continued From	page 4	F 282			
	During observation was observed to dining room. At 1 returned to the far get her bath that scheduled. R121 to give me my bar Friday so I guess home. It has been bath." During interview director of nursin unable to give a b it so the next shift the bath was not R22's quarterly M intact cognition, a assistance of one	on 11/19/14, at 11:50 a.m. R121 be sitting in her wheelchair in the 1:59 a.m. R121 stated she just cility on 11/7/14, so she did not week and on 11/14/14, as stated, "The staff never offered th and I am going home on I can take a bath when I go en over two weeks since I took a 11/20/14, at 12:00 p.m. the g (DON) stated if the staff are bath they are supposed to report t can give it. The DON verified documented as given.	F 202	followed consistently regarding ambulation have had their restor ambulation programs assessed adjusted to maintain or improve ambulation ability, as noted in the F-311. ROM-Residents who were cited having care plan interventions for consistently regarding ROM have their ROM programs adjusted to provided more consistently to m increase their ROM, as noted in for F-318. SKIN CARE-The resident who w for not having care plan intervent followed consistently regarding so prevention will continue to have monitoring and assessment of c skin issues to prevent the potent reoccurrence of a pressure ulce noted in the POC for F-314.	and their e POC for for not ollowed e had be aintain or the POC vas cited tions skin care urrent tial r, as	
	alteration in dress related to weakne intervention "assi R22. During observation resident was note sitting on her bed During an intervie	ed 6/12/2014, identified an sing, grooming, and bathing ess. The CP included the st of 1 for weekly bathing" for on on 11/17/2014 at 2:16 p.m., ed to be dressed for the day, and adjusting an earring. ew on 11/18/2014 at 1:39 p.m., resently gets one shower a		2.Actions taken to identify other residents having similar occurre BATHING-All residents that rece bathing have and will be evaluat continue receiving routing bathin continue good personal hygiene AMBULATION-All residents who benefit from a restorative ambul program have had their program assessed and adjusted to maint improve their ambulation ability. ROM-All residents who have bee	nces: vive ed to ig to could ation ation ain or	
	week, and added Sometimes they'n enough staff on t "I missed a show	"I'm lucky I get even that. "e too busy. They did not have o help me." R22 went on to say er for almost 2 weeks when I rsing home near the end of		assessed that may benefit from program have had their ROM pr adjusted to be provided more co to maintain or increase their RO SKIN CARE-All residents have a	a ROM ograms nsistently M.	

Facility ID: 00714

If continuation sheet Page 5 of 61

		H AND HUMAN SERVICES				FORM	12/29/2014 APPROVEE 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI				E SURVEY PLETED
	PROVIDER OR SUPPLIE	245513	B. WING	<u>етр</u>	EET ADDRESS, CITY, STATE, ZIP CODI		20/201 <u>4</u>
	DGE CARE CENTE			310	LAKE BOULEVARD FFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	Continued From	page 5	F 2	82			
	"I finally got my w A review of "Poin	stated that her family stepped in, reekly shower." t of Care History" for R22's d she had a shower on		a k	continue to have skin monitorir assessment completed with th pathing to prevent potential pre reoccurrence.	eir weekly	
	5/31/2014, then a document indicat R22 received "Pa indication R22 ha 5/31/14 and 6/13	again on 6/13/2014. The ed that on 6/7/14 and 6/12/14, artial" bed baths. There was no id received a shower between /2014. A review of "Bath Day is for R22 indicated 6/13/2014		f f t	3.Measures put in place to ensideficient practice does not rece BATHING-Bathing will be sche followed and each resident will east one full body bath once p and will be recorded on the bath the nurse and nursing assistant	ur: duled and receive at er week th sheet by nt. If a	
	registered nurse shower was giver computer program sheet." RN-D co	ew on 11/20/2014 at 2:33 p.m., (RN)-D said when a bath or n, "it is recorded in Matrix (a m) or on a resident's body audit uld not determine if R22 had a 1/14 and 6/13/2014.		t t a t	resident refuses or is not availated weekly bath, a bath will be scheduled with the a mutually agreed upon time we and will be documented by tha to having been refused and/or and was rescheduled on the back AMBULATION-Nursing will associated and was set to the back to the ba	make-up resident at <i>i</i> th a nurse t nurse as unavailable ath sheet.	
	A facility bathing was provided.	policy was requested, but none		r r a f V	residents who may benefit from restorative ambulation program admission, as needed, upon di from therapy and on a quarter When a resident starts a resto ambulation program, the care	n a n on ischarge y basis. rative	
	Restorative Nurs	ing: Ambulation		ι	updated along with a Restorati Program sheet. The nurse of	ve Nursing	
	9/30/14, included	ninimum data set (MDS) dated diagnoses of dementia, had impairment, needed assist of ion.		r p r a	monitor the restorative ambula program for their residents and responsible to make sure that assistants are completing the r ambulation programs per the g	tion d will be nursing restorative	
	received a restor 150 feet bid (twic transfer belt and to promote the re	lated 10/14/14, indicated she ative nursing program, ambulate e a day) with assist of one and a AROM (active range of motion) isident's ability to maintain or o the highest level of physical		F F r	care plan. ROM-A policy has been writter ROM programs. Nursing will a residents who may benefit from program on admission, as nee discharge from therapy and on	n regarding assess all n a ROM ded, upon	

Facility ID: 00714

CENTER	<u>RS FOR MEDICAI</u>	RE & MEDICAID SERVICES			OMB NO.	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
		245513	B. WING			20/201 <u>4</u>
NAME OF F	PROVIDER OR SUPPLIE	R		TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTE	R OF BUFFALO	-	10 LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 282	Continued From	page 6	F 282			
F 282	functioning. A Neurophysical systems of the facility RN (rn Nursing Monthly indicated R66 waliving related to dreview indicated R66 waliving related to dreview indicated met and had only 30 days, and has weakness. The rno changes at the R66's AROM goal comb own hair at refusals due to corplan of care. Review of Point of following: September 2014 opportunities. The unavailable three 8 times. The his not ambulate the October 2014- at the Review of Point of the section	egistered nurse) Restorative Review dated 10/28/14, as at risk for activity's of daily iagnosis and condition. The R66's ambulation goal was not ambulated four times in the last a had recent medical issues, and review indicated that there were is time continue with care plan. al indicated goal met continue to and apply her makeup, did have condition in last 30 days continue of Care History indicated the - ambulated 11 times out of 60 he history indicated she was times, deferred due to condition tory did not indicate why R66 did remainder 38 times. - mbulated 14 times out of 62	F 282	basis. When a resident starts program, the care plan will be along with a Restorative Nursir sheet. The nurse of the unit with ROM program for their resi will be responsible to make sur nursing assistants are complete ROM programs per the goals of plan. Activities programming in facility exercise programs weel routine basis, which include ex both upper and lower extremitin Activities will update nursing if involved in these programs are attending so programs can be SKIN CARE-Thorough inspect integrity will be done with all ne admissions, hospital returns ar with weekly bathing by the nurs unit on the Skin Assessment A Any potential skin issues will be communicated to the Clinical O and Director of Nursing so ass can be made, care plan updati completed and needed interver be put in place to prevent furth breakdown or progression of w	updated ng Program ill monitor dents and re that ing the of the care ncludes 3-5 kly on a ercises for es. residents e no longer adjusted. ions of skin ew nd along se of that udit form. essment ng can be ntions can er vounds.	
	unavailable once twice and deferre	ne history indicated she was , refused once, not observed ed due to condition four times. ot indicate why R66 did not		be monitored by: BATHING-Each unit nurse will responsible for monitoring that done for each resident on that	bathing is	
	ambulate the ren	nainder 40 times.		be confirmed by signing the ba each weekly bath. Those bath	th sheet for ing	
	ambulated 11 tim history indicated	ru November 19th 2014- les out of 38 opportunities. The she was unavailable three times to condition three times. The		documents will be reviewed we Director of Nursing for complia three months, and then monthl Performance on the effectiven	nce for y.	

Facility ID: 00714

If continuation sheet Page 7 of 61

		TH AND HUMAN SERVICES RE & MEDICAID SERVICES	1		PRINTED: 12/29/201 FORM APPROVEI OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED
	PROVIDER OR SUPPLIE	<b>245513</b>	B. WING	STREET ADDRESS, CITY, STATE, ZIP COD	11/20/201 <u>4</u>
	DGE CARE CENTE		1 3	BUFFALO, MN 55313	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETIO
F 282	Continued From	page 7	F 282		
	history did not inc the remaining 27	licate why R66 did not ambulate opportunities.		completed bathing schedules presented to the QAPI commi consecutive quarters for contin compliance.	ttee for two
	assistant (NA)-D	11/19/14, at 9:01 a.m. nursing stated she is unable to ambulate to not having enough staff in the		AMBULATION-Monitored and Restorative Nursing Program be collected by the Director of from the unit nurses on a wee insure completeness proper p	sheets will Nursing kly basis to
	therapy assistant therapy and had placed on a resto the nurses note a refusing they are these changes. staff had not info ambulating or we restorative nursin	11/20/14, at 10:42 a.m physical (PTA)-A stated R66 was in been refusing so she had been prative nursing rehab program. If a decline or if a resident is supposed to inform therapy of The PTA-A stated the nursing rmed her R66 had not been re unable to complete the ng due to staffing concerns but n running around and they seem		have been followed. A summa report of the restorative ambul program compliance will be pr the QAPI committee quarterly two quarters, and then as nee discretion of the QAPI commit ROM-Monitored and complete Restorative Nursing Program be collected by the Director of from the unit nurses on a wee insure completeness proper p have been followed. A summa report of the ROM program co	ary activity lation rovided to meeting for ded at the ttee. ed sheets will Nursing kly basis to rocedures ary activity
	Physical Therapis the hallway with a	on 11/20/14 at 11:44 a.m. at (PT)-G was ambulating R66 in a rolling walker and transfer belt -G stated R66 has not declined a.		will be provided to the QAPI co quarterly meeting for two quar then as needed at the discretic QAPI committee. SKIN CARE-The Director of N collect and monitor the Skin A Audit forms monthly for contin	ommittee ters, and on of the lursing will ssessment
	had hypertension impaired needed and used a walke dated 1/26/14, ind with all ADL's due dementia. The C	IDS dated 09/09/14, indicated he and was moderately cognitively assist of one to walk in corridor er and a wheelchair. R73's CAA dicated he needed assistance to Parkinson's Disease and CAA further indicated he was		compliance and follow-up for s The Director of Nursing will re assessment and monitoring co the QAPI committee for two qu Further need for monitoring wi evaluated by the QAPI commi	six months. port skin ompliance to uarters. ill be ttee.
		OT (occupational therapy) ing very little progress.		5.Those responsible to mainta compliance will be: The Director of Nursing or des	

Facility ID: 00714

If continuation sheet Page 8 of 61

TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DAT	0938-039 SURVEY PLETED
NAME OF	PROVIDER OR SUPPLIE	<b>245513</b>	B. WING	TREET ADDRESS, CITY, STATE, ZIP CO		20/201 <u>4</u>
	DGE CARE CENTE		3,	10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 282	R73's care plan of received restorati promote his abilit to the highest lew was to ambulate walker 200 feet of assistant care sh ambulate with rol with w/c (wheelch feet or as tolerate R73's Restorative 04/09/14, initiated walking program transfer belt BID. Review of R73's Review dated Oc walked 200' (feet did have increase and antidepressa Resident tolerate POC (plan of care September 2014- opportunities, refi condition 8 times reason why R73 37 times. October 2014- ar opportunities, refi and deferred due	lated 2/25/14, indicated he ive nursing ambulation to y to maintain or restore function el of physical functioning. R73 with assist of one and rolling r as tolerated. R73's nursing eet indicated he was to ling walker and assist of one hair) to and from meals and 100 ed BID (twice a day). e Nursing Program dated d by a unknown PTA indicated assist of rolling walker and RN Restorative Nursing Monthly tober 2014, indicate "Resident ) five out of 26 days. Resident e in a antiparkinson's medication int medication 10/08/14. d ambulating fair. Will continue e)." e History indicated the following: - ambulated 14 times out of 60 used 3 times, deferred due to . The history did not indicate the did not ambulate the remaining mbulated 21 times out of 62 used once, not observed 8 times to condition 7 times. The dicate why he did not ambulate		be responsible for maintainin with consistently implementin interventions for bathing, am ROM and skin care. Completion date for certification only is: December 22, 201	ng care plan ibulation, tion purposes	

If continuation sheet Page 9 of 61

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	12/29/2014 APPROVED 0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245513	B. WING		11/2	20/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	LAKE RIDGE CARE CENTER OF BUFFALO			310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 282	refused 3 times, de times. The history not ambulate the re During interview 11 stated she has not	s out of 38 opportunities, eferred due to condition 8 did not indicate why R73 did	F 282			
	she had arthritis ar ambulated with lim and used a walker CAA indicated she has attended PT at highest level of fun program in place. R42's care plan da alteration in mobilit ambulates per rest and walker. The facility had a T	OS dated 09/16/14, indicated and was cognitively intact ited assist of two in corridor and a wheelchair. R42;s ADL needed assistance with ADL's and OT in the past and at her ction and had a restorative ted 6/28/14, indicated she had y related to weakness and orative program assist of one Therapy Assessment- PT O REHAB dated 09/06/13,				
	continue with nursi day). The facility Restora 10/19/11, initiated to ambulate 100 feet belt twice a day. A RN Restorative N	r last day of therapy and was to ng and walking BID (twice a ative Nursing Program dated by PTA-A indicated R42 was to with rolling walker, and transfer Nursing Monthly Review dated I R42 ambulated 100 feet 25				

If continuation sheet Page 10 of 61

		AND HUMAN SERVICES			FORM	12/29/2014 APPROVED 0938-0391
-	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		11/;	20/2014
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	LAKE RIDGE CARE CENTER OF BUFFALO			10 LAKE BOULEVARD BUFFALO, MN 55313		_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 282	less than 100 feet a least 50% of days i well and program w other day) to reflec see care plan for fu note indicated the p to qod the Restorat identify these chan Review of the Point following: September 2014- a opportunities, not o information was do did not indicate why remaining 22 times October 2014- amb times, and there wa The history did not ambulate the rema November 1st thru ambulated 22 times why R42 did not an times. During interview 11 stated she is the or today for 13 residen NA's on her unit. N	<ul> <li>A sident continues to ambulate and is not completing daily. At in the past month she tolerates was changed to qod (every tresidents current progress urther details. Although the program was changed from bid tive Nursing Program did not ges.</li> <li>t of Care History indicated the ambulated 35 times out of 60 observed twice and no ocumented once. The history y R42 did not ambulate the s.</li> <li>coulated 34 times out of 62 as no information 14 times. indicate why R42 did not indicate moulate the remaining 48 times.</li> <li>November 19th 2014-s out of 38, there was no s. The history did not indicate moulate the remaining 16</li> <li>r/19/14, at 9:01 a.m. NA- D haly one working on her unit ints and they should have two NA-D said this happens at least because of that sometimes the</li> </ul>				

If continuation sheet Page 11 of 61

		AND HUMAN SERVICES			FORM	12/29/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		11/:	20/2014
NAME OF I	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO		10 LAKE BOULEVARD		
				SUFFALO, MN 55313		0.(7)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	Continued From pa	age 11	F 282			
		/20/14, at 10:51 a.m. PTA-A				
		ative Nursing Program Ild ambulate BID. PTA-A also				
	indicated the restor	rative nursing rehab program				
		the clinical coordinator and le to let us know if the resident				
	is declining or not p	participating in the program.				
		she had been told the programs were not being				
	implemented.	programs were not being				
	PT-A stated the clin of the restorative p DON oversaw the stated the nursing resident was not pa injury with a fall. T	/20/14, at 11:25 a.m. with nical coordinators are in charge rogram and they thought the program also. The PT-A staff are to inform us if a articipating, had a decline or an he PT-A stated they were not rative programs were not being				
	stated there have to just isn't enough st programs and there	/20/14, at 12:05 p.m., the DON been some days where there aff to complete the restorative e are days she was working on s it just can not get completed.				
	clinical coordinator stated the nursing there restorative nu informed they were	/20/14, at 1:50 p.m. with registered nurse (RN)-D assistance are to complete ursing and she was not unable to complete there bove residents as written.				
	had seizure disord further indicated sh	S dated 10/07/14, indicated she er and hypertension. The MDS ne was cognitively intact and assist of two with dressing, and				

If continuation sheet Page 12 of 61

		AND HUMAN SERVICES			FORM	12/29/2014 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		11/2	20/2014
NAME OF F	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	LAKE RIDGE CARE CENTER OF BUFFALO			10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	)PRIATE	DATE
F 282	Continued From pa	age 12	F 282			
		al hygiene and had no				
		upper extremity (UE) and E). R5's care area assessment				
		/14, indicated she needed				
	to weakness relate	DL's (activity of daily living) due ad to osteoarthritis and is at her				
	highest level of fun	ctioning.				
		ed 08/05/14, indicated she				
		dressing, bathing and grooming e to two with all ADL's. The				
		she received AROM.				
		by note dated 10/26/11, ived OT pt had limited UE				
	ROM and fatigued	easily with tasks and she				
		er body dressing and ith LE dressing. The note				
	further indicated for nursing program.	r patient to resume restorative				
		g Program recommended by				
		0/21/11, indicated she was to JE and LE for 15 minutes once				
	a day.					
		Irsing Monthly Review dated				
		d she had no changes in her wement and did not need OT				
	referral. The sumr	mary of her goal of to continue				
		of body and use stand for she continues to complete				
	AROM program wi	th meeting goal. Has				
		of 30 days. Tolerates fair to riate unable to progress to				
		ue to maintain current mobility				
	The Point of Care	History indicated the following:				

If continuation sheet Page 13 of 61

STATEMENT OF DEFICIENCIES       (X1) PROVIDERSUPPLIERCIAN IDENTIFICATION NUMBER:       (X2) MULTIFILE CONSTRUCTION A BULINNE       (V3) DUALINE A BULINNE			I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	12/29/2014 APPROVED 0938-0391
MAKE OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       INTRODUCES       TAG     STREET ADDRESS, CITY, STATE, ZIP CODE       INTRODUCES       MILL       PROVIDER ADD CONRECTION       Construction       PROVIDER ADD OF CORRECTION       CONSTRUCT OF DEFICIENCES       PROVIDER ADD OF CORRECTION       PROVIDER ADD OF CORRECTION       CONSTRUCT OF DEFICIENCES       PROVIDER ADD OF CORRECTION       PROVIDER ADD OF CORRECTION       CONSTRUCT OF PROPERVATE       CONSTRUCT OF DEFICIENCY       PROVIDER ADD OF CORRECTION       PROVIDER ADD OF CORRECTION       CONSTRUCT OF DEFICIENCY       F 282       Continued From page 13       F 282       October 2014- AROM 27 out of 31 opportunities and refused One: The history did not indicate why she did not receive AROM for 15 minutes or greater the only one				. ,			
NME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE. ZIP CODE       LAKE RIDGE CARE CENTER OF BUFFALO     310 LAKE BOULEVARD BUFFALO, MN 55313       MID PREFX TAG     SUMMARY STATEMENT OF DEFICIENCIES RECOLLATORY OR LSC IDENTIFYING INFORMATION)     PROVIDER'S ACH CORRECTIVE ATON SHOULD BAC RECOLLATORY OR LSC IDENTIFYING INFORMATION)     D PREFX TAG     PROVIDER'S ACH CORRECTIVE ATON SHOULD BAC RECOLLATORY OR LSC IDENTIFYING INFORMATION)     PREFX TAG     PROVIDER'S ACH CORRECTIVE ATON SHOULD BAC RECOLLATORY OR LSC IDENTIFYING INFORMATION)     D PREFX TAG     PROVIDER'S ACH CORRECTIVE ATON SHOULD BAC RECOLLATORY OR LSC IDENTIFYING INFORMATION)     PREFX TAG     PROVIDER'S ACH CORRECTIVE ATON SHOULD BAC RECOLLATORY OR LSC IDENTIFYING INFORMATION)     D PREFX TAG     PROVIDER'S ACH CORRECTIVE ATON SHOULD BAC RECOLLATORY OR LSC IDENTIFYING INFORMATION)     PREFX TAG     PROVIDER'S ACH CORRECTIVE ATON SHOULD BAC RECOLLATORY OR LSC IDENTIFYING INFORMATION)     D PREFX TAG     PROVIDER'S ACH CORRECTIVE ATON SHOULD BAC RECOLLATORY OR LSC IDENTIFYING INFORMATION)     D PREFX TAG     PROVIDER'S ACH CORRECTIVE ATON RECOLLATORY OR LSC IDENTIFYING INFORMATION)     D PREFX TAG     PROVIDEN'S ACH CORRECTIVE ATON RECOLLATORY OR LSC IDENTIFYING INFORMATION     D PREFX TAG     PROVIDEN'S PREFX TAG     PROVIDEN'S PREFX TAG     PROVIDEN'S PREFX TAG     PROVIDEN'S PREFX TAG     PROVIDEN'S PREFX TAG     PREFX TAG     PREFX TAG <td></td> <td></td> <td>245513</td> <td>B. WING</td> <td></td> <td>11/2</td> <td>20/2014</td>			245513	B. WING		11/2	20/2014
LAKE RIDGE CARE CENTER OF BUFFALO     BUFFALO, MN 55313            [Mu] ID [Ack DEPCICENCY MUST BE RECEIPED BY FULL [Ack DEPCICENCY MUST BE REACEEPED BY FULL [Ack DEPCICENCY BE RECEIPED BY FULL [Ack DEPCICENCY MUST BE REACEEPED BY FULL [Ack DEPCICENCY MUST BE REACEEPED BY FULL [Ack DEPCICENCY MUST BE REACEEPED BY FULL [Ack DEPCICENCY MUST BE REACE [Ack DEPCICENCY MUST BE REACEEPED BY FULL [Ack DEPCICENCY MUST BE REACE [Ack DEPCICENCY MUST BE REACEEPED BY FULL [Ack DEPCICENCY MUST BE REACEEPED BY FULL [Ack DEPCICENCY MUST BE REACEEPED BY FULL [Ack DEPCICENC	NAME OF F	PROVIDER OR SUPPLIER					
Precisive TAG       (EACH OPERIGENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       CEACH OPERITY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE       COMPLETION DEFICIENCY)         F 282       Continued From page 13       F 282         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.       F 282         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 St 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 care the 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 Jaso. 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 being done.         During interview 11/20/14, at 12:05 p.m., the DON state there have been some days where there	LAKE RI	DGE CARE CENTER	OF BUFFALO				
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 though 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 being done. During interview 11/20/14, at 12:05 p.m., the DON stated the have been some days where there	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
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	F 282	Continued From pa	age 13	F 282			
just isn't enough staff to complete the restorative programs and there are days she is working on		greater 18 out of 3 times. The history not receive AROM October 2014- ARG and refused once. why she did not red days. November 1st thru received for 15 mir of 19 opportunities why R5 did not rec greater the remain During interview 11 stated she is the or today for 13 reside NA's on her unit. Nonce a week and b restorative nursing During interview 11 who stated the clin of the restorative poversaw the progra nursing staff are to participating, has a fall. The PT stated restorative program During interview 11 stated there have b just isn't enough st	D opportunities, and refused 3 did not indicate why she did the remaining 12 times. DM 27 out of 31 opportunities The history did not indicate ceive ROM the remaining four November 19th 2014- AROM nutes or more occurred 16 out . The history did not indicate eive AROM for 15 minutes or ing 3 opportunities. /19/14, at 9:01 a.m. NA- D hly one working on her unit nts and they should have two NA-D said this happens at least because of that sometimes the programs cant get done. /20/14, at 11:25 a.m. with PT ical coordinators are in charge rogram and thought the DON am also. The PT stated the inform us if a resident is not decline or has an injury with a they were not informed the ns were not being done. /20/14, at 12:05 p.m., the DON been some days where there aff to complete the restorative				

		AND HUMAN SERVICES			FORM	12/29/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		11/:	20/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	-	10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	clinical coordinator stated the nursing there restorative nu informed they were programs. RESTORATIVE NU R66's quarterly mir 9/30/14, included of severe cognitive in upper (UE) and low R66's care plan da received a restorat (active range of mo resident's ability to the highest level of During observation was observed to be down the hall indep indication that R66 program. The RN (registered Monthly Review da was at risk for ADL and condition. The AROM goal was m own hair, apply ma due to medical cor continue plan of ca The facility had a T FORM Occupation indicated R66's Oc	<ul> <li>J/20/14, at 1:50 p.m. with registered nurse (RN)-D who assistance are to complete ursing and that she was not e unable to complete there</li> <li>JRSING ROM himum data set (MDS) dated diagnoses of dementia, had hpairment, no limitation in ver extremity (LE).</li> <li>ted 10/14/14, indicated she ive nursing program, AROM biton) daily to promote the maintain or restore function to physical functioning.</li> <li>11/19/14, at 12:00 p.m. R66 e in her wheelchair wheeling bendently, there was no recieved her AROM excercise</li> <li>d nurse) Restorative Nursing ted 10/28/14, indicated R66 decline related to diagnosis e Review indicated R66's let and to continue to comb skeup, and had some refusals ndition in last 30 days but to are.</li> <li>Therapy Assessment 701 al Therapy form dated 7/22/14, coupational Therapy (OT) was</li> </ul>	F 282			
	due to medical con continue plan of ca The facility had a T FORM Occupation indicated R66's Oc	ndition in last 30 days but to are. Therapy Assessment 701 al Therapy form dated 7/22/14,				

If continuation sheet Page 15 of 61

		AND HUMAN SERVICES			FORM	12/29/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245513	B. WING		11/2	20/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RIDGE CARE CENTER OF BUFFALO			10 LAKE BOULEVARD BUFFALO, MN 55313			
()(4) ID	SI IMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	COMPLETION DATE
F 282	Continued From pa	age 15	F 282			
		The form identified "Res				
		continued) rx (treatment), dc to cellulitis to hand. At time of dc				
	res was not partici	pation with therapy refused last				
		eded max verbal and tactile the other dates of service.				
	She was able to pr	opel wc short distances in SNF				
		ility) using LE (lower extremity) E (upper extremity) on				
		cued to do so." Although OT				
		on 7/22/14, the form did not				
	implemented or no	e nursing program was to be t.				
		torative Nursing Program dated recommended by physical				
	therapy assist (PT/	A)-A indicated AROM program mity) and LE (lower extremity)				
	Review of Point of following:	Care History indicated the				
	September 2014-A of 30 opportunities	ROM completed 30 times out				
	31 opportunities, d	OM completed 16 times out of eferred due to condition three erved twice. The Point of Care				
	History did not indi	cate why R66 did not receive ng 10 opportunities.				
	completed 10 time Point of Care Histo	November 19th 2014- AROM s out of 19 opportunities, the bry did not indicate why R66 did the remaining 0 opportunities				
	not receive AROM	the remaining 9 opportunities.				
	During interview 11	/19/14, at 9:05 a.m. NA- D				

		AND HUMAN SERVICES			PRINTED: 12/29/ FORM APPRC OMB NO. 0938-	OVED
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		11/20/201	4
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		-
LAKE RI	DGE CARE CENTER	OF BUFFALO		10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID	SUMMARY ST	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ΓΙΟΝ (Χε	5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPL	ÉTION
F 282	Continued From pa	age 16	F 282			
		nt staffed and she is unable to n R66 a lot of the time due to time.				
	stated she was not receiving her AROI care. OT-A further are supposed to let	/20/14, at 11:25 a.m. OT-A aware that R66 was not M according to her plan of stated the clinical coordinators therapy know if residents are re programs and they had not				
	OT-A was observe	11/20/14, at 11:50 a.m. the d to provide AROM with R66 dent remained unchanged and II ROM.				
	was cognitively inta anemia. The MDS extensive assist of impairment on ons impairment on her indicated she need due to multiple diag attended PT and O highest level of fun place. R42's care plan da received AROM to or restore function	S dated 9/16/14, indicated she act, had hypertension and further indicated she needed one with ADL's and had ide of her UE and no LE. R42's CAA dated 4/15/14, ed assistance with all ADL's gnosis including arthritis. Has T in the past and was at her ction, restorative program in ted 10/21/14, indicated she promote her ability to maintain to the highest level of physical				
	AROM to UE and L	are plan indicated she needed E daily for 15 minutes may exercises, thera-band, hand ball.				

		AND HUMAN SERVICES			FORM	12/29/2014 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245513	B. WING		11/2	20/2014
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE R	DGE CARE CENTER	OF BUFFALO		10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	The Therapy Asset dated 09/06/13, co received OT five tin and met goals with motivation and no and was discontinu and participate on program as tolerate Restorative Nursin indicated she was 15 minutes daily. RN Restorative Nur 10/21/14, indicated was to dress upper The summary of of appropriate. Staff a goal to a more app complete AROM per fair to good. The si had no changes in since last review. The Point of Care September 2014- A opportunities. The AROM several time October 2014- reco opportunities, no inf five times. No info did not receive ARC November 2014- reco opportunities.	ssment Occupational Therapy mpleted by OT, indicated she mes a week for 23 sessions bilateral UE she has low longer required OT services ued. R42 was to stay long term nursing restorative and walk ed. g Program dated 10/19/11, receive AROM to UE and LE rsing Monthly Review dated d no need for OT referral and r extremity with set up assist. f the goal indicated goal not assist with dressing change propriate one does continue to rogram daily tolerates program summary also indicated she her ROM voluntary movement History indicated the following: AROM 29 out of 30 history indicated R42 received	F 282			

If continuation sheet Page 18 of 61

		I AND HUMAN SERVICES E & MEDICAID SERVICES				12/29/2014 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE COMF	SURVEY PLETED
		245513	B. WING		11/2	0/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
LAKE RI	DGE CARE CENTER	OF BUFFALO		310 LAKE BOULEVARD BUFFALO, MN 55313		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ΓΙΟΝ	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETION DATE
F 282	Continued From pa	age 18	F 282			
		at she should and when they is impossible to get her work				
	had seizure disord further indicated sh needed extensive a assist with persona impairment on her assessment (CAA) needed assistance living) due to weak and is at her highe R5's care plan date needs assist with on needs assist of one care plan indicated Occupation Therap indicated she recein and fatigued easily upper body dressir	S dated 10/07/14, indicated she er and hypertension. The MDS he was cognitively intact and assist of two with dressing, and al hygiene and had no UE and LE. R5's care area dated 10/07/14, indicated she with ADL's (activity of daily ness related to osteoarthritis st level of functioning. ed 08/05/14, indicated she Iressing, bathing and grooming e to two with all ADL's. The she received AROM. by note dated 10/26/11, ved OT for limited UE ROM with tasks. She participated in ng and maximum assist with LE e further indicated for patient to nursing program.				
	"therapies" dated 1	g Program recommended by 0/21/11, indicated she was to JE and LE for 15 minutes once				
	10/21/14, indicated ROM/voluntary mo referral. The sumr	rsing Monthly Review dated I she had no changes in her vement and did not need a OT nary of her goal was to Ipper half of body and use				

If continuation sheet Page 19 of 61

		AND HUMAN SERVICES			FORM	12/29/2014 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING			E SURVEY PLETED
		245513	B. WING		11/:	20/2014
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO		10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 282	complete AROM procompleted 27 out of good, goal appropring higher level continuities why R5 did not recompleted 27 out of good, goal appropring the sector of the sector o	age 19 indicated she continues to rogram with meeting goal. Has of 30 days. Tolerates fair to iate unable to progress to ue to maintain current mobility History indicated the following: AROM occurred 15 minutes or 0 opportunities, and refused 3 did not indicate why she did the remaining 12 times. OM 27 out of 31 opportunities The history did not indicate ceive ROM the remaining four November 19th 2014- AROM outes or more occurred 16 out . The history did not indicate eive AROM for 15 minutes or ing four opportunities.	F 282			
	stated she was the today for 13 reside NA's on her unit. N once a week and b	/19/14, at 9:01 a.m. NA- D only one working on her unit nts and they should have two IA-D said this happens at least ecause of that the restorative can not get completed.				
	PT-A stated the clir charge of the resto DON oversaw the p nursing staff are to	/20/14, at 11:25 a.m. with nical coordinators were in rative program and thought the program also. PT-A stated the inform us if a resident is not decline or has an injury with a				

If continuation sheet Page 20 of 61

		AND HUMAN SERVICES			FORM /	12/29/2014 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE COMF	E SURVEY PLETED
		245513	B. WING		11/2	20/2014
NAME OF I	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		.0/20 14
LAKE RI	DGE CARE CENTER	OF BUFFALO		10 LAKE BOULEVARD		
			E	SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	Continued From pa	age 20	F 282			
	fall. They were not programs were not	t informed the restorative being completed as	1 202			
	assessed.					
	stated there have b	/20/14, at 12:05 p.m., the DON peen some days where there				
	programs and there	aff to complete the restorative e are days she is working on				
	DON stated the nu	s it just can not get done. The rsing staff had been trained in				
	facility specific poli	grams and they do not have a cy but they follow the RAI ent instrument) manual.				
	clinical coordinator	/20/14, at 1:50 p.m. with registered nurse (RN)-D who				
		assistance are to complete ursing and that she was not				
		unable to complete there				
		d training 4/01/14 and 4/2/14				
	Restorative Nursin	nursing assistance, on g Programs. The training				
		"Each resident who is on a program has been assessed				
		ound to be appropriate and rams listed on the restorative				
		our care books behind the				
	-	et. Any information about the				
		what programs and how often found there and the Clinical				
	Coordinator can ar	nswer any questions you may				
		gram or address it if you find ble or unwilling to follow the				
	program. Once yo	u have been educated on the				
		esident, please sign/date at the t. You are required to follow				
		sing programs for our residents				

If continuation sheet Page 21 of 61

		AND HUMAN SERVICES			FORM	12/29/2014 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING			E SURVEY PLETED
		245513	B. WING		11/2	20/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	-	10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETION DATE
F 282	Continued From pa	age 21	F 282			
		e with their plan of care - so				
	indicated intact cog breakdown, left sid affects of recent st	KIN CARE essment MDS dated 11/11/14, gnition, at high risk for skin ded weakness from residual roke, assist of two person for st of two persons for bed				
	indicated " potentia seizures, decrease arthritis, recent CV of stasis ulcers( op circulation) and Pa pressure ulcers/ sk pressure to right ar	skin integrity dated 10/14/14 al in skin integrity related to ad mobility due to recent A (left sided weakness) history en areas from poor venous rkinson's disease. At risk for kin breakdown/injury. Avoid hkle and encourage resident to leg up on pillow (elevation to				
	a.m., R18 was in b center but not in a His head was supp of bed was raised	of R18 on 11/19/14, at 7:04 ed lying on his back slightly off position to slide off of the bed. oorted with one pillow and head @ 30 degrees. He was h no pillow under his bilateral				
	p.m., R18 was obs	of R18 on 11/19/14 at 2:01 erved lying on his back, there rovided under his legs for				

If continuation sheet Page 22 of 61

		I AND HUMAN SERVICES E & MEDICAID SERVICES		FC	ED: 12/29/2014 RM APPROVED NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		DATE SURVEY COMPLETED
		245513	B. WING		11/20/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE RI	DGE CARE CENTER	OF BUFFALO		10 LAKE BOULEVARD SUFFALO, MN 55313	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	p.m., R18 was on H was no pillow or su During observation 3:14p.m., R18 was there was no pillow legs. Licensed prac- in the room at this be floated on a pillo present stated his The facility assign CARE CENTER C. followed by nursing identify R18's legs indicated in care pl	of R18 on 11/20/14 at 2:28 his back head elevated there apport provided for his legs. of R18 on 11/20/14 at is in bed with HOB elevated, or support provided for his ctical nurse (LPN)-A who was time verified R18's feet were to bw. NA-C who was also feet will not stay on a pillow. nent sheet titled LAKE RIDGE ARE SHEETS, which is g assistants for cares did not were to be elevated as an dated 10/14/14.	F 282		
F 311 SS=D	the director of nurs plan should be follo She did state R18 elevation of legs bu re-approached or a legs. The clinical c updating the care p changes for reside 483.25(a)(2) TREA IMPROVE/MAINTA A resident is given services to maintai specified in paragra This REQUIREME by: Based on observa	an alternate used to support oordinators are responsible for plans and nursing staff on nts' cares. TMENT/SERVICES TO	F 311	F311-D This Plan of Correction constitutes my	12/22/14

Facility ID: 00714

If continuation sheet Page 23 of 61

			-	1 APPROVEI ). 0938-039	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
$2 \cap ($	245513	B. WING		/20/201 <u>4</u>	
PROVIDER OR SUPPLIE	R				
DGE CARE CENTE	R OF BUFFALO				
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
Continued From	bage 23	F 311			
consistently imple services to impro ambulation ability and R42) reviewe Findings include: R66's quarterly m 9/30/14, included severe cognitive i one with ambulat assessment (CA/ was at high risk for three months. R66's care plan of received a restora 150 feet bid (twic transfer belt to pr maintain or restor	ement restorative ambulation ve and/or maintain the resident's for 3 of 4 residents (R66, R73 ed for ambulation. inimum data set (MDS) dated diagnoses of dementia, had impairment, needed assist of ion. R66's care area A) dated 7/15/14, indicated she or falls, had three falls in the last lated 10/14/14, indicated she ative nursing program, ambulate e a day) with assist of one and a omote the resident's ability to re function to the highest level of		and adjusted to maintain or improve their	1	
recommended by indicated a walkin During observation was observed to down the hall indefect to propel. During interview of stated they are no due to staffing. S	physical therapy assist (PTA)-A ng program 100 feet twice a day. on 11/19/14, at 12:00 p.m. R66 be in her wheelchair wheeling ependently using her hands and 11/19/14, at 9:05 a.m. NA- D ot always able to ambulate R66 she indicated they are short all		benefit from a restorative ambulation program on admission, as needed, upon		
	RS FOR MEDICAF         OF DEFICIENCIES         OF DEFICIENCIES         OF CORRECTION         DROVIDER OR SUPPLIE         DGE CARE CENTE         SUMMARY S         (EACH DEFICIEN         REGULATORY OF         Continued From I         consistently impleservices to impro         ambulation ability         and R42) reviewed         Findings include:         R66's quarterly m         9/30/14, included         severe cognitive i         one with ambulati         assessment (CAA)         was at high risk for         three months.         R66's care plan of         received a restora         150 feet bid (twict         transfer belt to pr         maintain or restor         physical functioni         The Restorative for         recommended by         indicated a walkir         During observation         was observed to         down the hall indof         feet to propel.         During interview         stated they are no         due to staffing. Stime and just can         done.	IDENTIFICATION NUMBER:         245513         DROVIDER OR SUPPLIER         DGE CARE CENTER OF BUFFALO         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 23 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	2S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPL         A. BUILDING       245513       B. WING         PROVIDER OR SUPPLIER       245513       B. WING         SUMMARY STATEMENT OF DEFICIENCIES       ID       PREFIX         TGE CARE CENTER OF BUFFALO       ID       PREFIX         SUMMARY STATEMENT OF DEFICIENCIES       ID       PREFIX         TGEQUATORY OR LSC IDENTIFYING INFORMATION)       F 311         Continued From page 23       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.       F 311         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 u	Restorative and R42 preview dramating restorative and R42 preview of a mabulation.         F 311         F 311           R66's care plan dated 10/14/14, indicated she received a restorative nursing program dated 2/14/14 recommended by physical therapy assist (PTA). A difficultation of the restorative nursing program dated 2/14/14 restorative ambulation for the restorative nursing program dated 2/14/14 restorative ambulation for the restorative nursing program dated 2/14/14 restorative ambulation for the restorative nursing program dated 2/14/14 restorative ambulation for maintain or improve their ambulation for ambulation for aday. She indicated they are not always able to ambulate R66 due to staffing. She indicated they are not always able to ambulate R66 due to staffing. She indicated they are not always able to ambulate R66 due to staffing. She indicated they are not always able to ambulate R66 due to staffing. She indicated they are not always able to ambulate R66 due to staffing. She indicated they are not always able to ambulate R66 due to staffing. She indicated they are not always able to ambulate R66 due to staffing. She indicated they are not always able to ambulate R66 due to staffing. She indicated they are not always able to ambulate R66 due to staffing. She indicated they	

Facility ID: 00714

		RE & MEDICAID SERVICES				0938-039
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
		245513	B. WING	-FIN		20/201 <u>4</u>
NAME OF	PROVIDER OR SUPPLIE	R		TREET ADDRESS, CITY, STATE, ZIP CODI		
LAKE RI	DGE CARE CENTE	R OF BUFFALO	-	10 LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 311	Continued From	page 24	F 311			
	indicated R66 is diagnosis and co R66's ambulation ambulated four ti have recent blee weakness. No ci care plan. R66's continue to comb makeup, did hav 30 days continue The facility HCFA Administration) a recetification of ti "PT was discontii weakness and de patient was recen medical status." was transferring of one. Had amb one up to 70 feet unexpected due therapy was disc R66's restorative During interview assistant (NA)-D ambulate R66 at staff in the facility Review of Point of following: September 2014 opportunities. Th unavailable three 8 times. The his	at risk for ADL decline related to indition. The Review indicated in goal was not met has only mes in the last 30 days, does ding issues from rectum and hanges at this time continue with AROM goal indicated goal met o own hair and apply her e refusals due to condition in last plan of care. A 701 (Health Care Finacing (form used for medicare herapy) dated 7/08/14, indicated nued secondary to progressive ecline in medical status and the htly hospitalized due to decline in The form futher indicated she with moderate to minimal assist pulation with moderate assist of and d/c [discharge] was to hospitalization." Although ontinued the form did not identify rehab nursing. 11/19/14, at 9:01 a.m. nursing stated she was unable to times due to not having enough		plan will be updated along with Restorative Nursing Program s nurse of the unit will monitor the restorative ambulation program residents and will be responsite sure that nursing assistants and completing the restorative ambu- programs per the goals of the 4.Effective implementation of a be monitored by: Monitored and completed Rest Nursing Program sheets will be by the Director of Nursing from nurses on a weekly basis to ins completeness proper procedur been followed. A summary act of the restorative ambulation p compliance will be provided to committee quarterly meeting for quarters, and then as needed discretion of the QAPI committe 5.Those responsible to maintata compliance will be: The Director of Nursing or des be responsible for maintaining with restorative ambulation pro- Completion date for certification only is: December 22, 2014	sheet. The le of for their ole to make e oulation care plan. actions will torative e collected of the unit sure res have tivity report rogram the QAPI or two at the see. in ignee will compliance ograms.	

If continuation sheet Page 25 of 61

		AND HUMAN SERVICES			FORM	12/29/2014 APPROVED 0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING			E SURVEY PLETED
		245513	B. WING		11/2	20/2014
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO		10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 311	opportunities. The unavailable once, r twice and deferred The history did not ambulate the rema November 1st thru ambulated 11 times history indicated sh and deferred due to history did not indic the remaining 21 o During interview 11 stated R66 was in so she had been p rehab program. If t resident is refusing therapy of these ch nursing staff had n been ambulating. was not informed to compete the restor concerns but states and they seem very During observation Physical Therapist ambulate R66 in th with a rolling walke PT stated R66 has ambulation. R73's quarterly MD	bulated 14 times out of 62 history indicated she was refused once, not observed due to condition four times. indicate why R66 did not inder 40 times. November 19th 2014- s out of 60 opportunities. The ne was unavailable three times o condition three times. The cate why R66 did not ambulate pportunities. //20/14, at 10:42 a.m PTA-A therapy and had been refusing laced on a restorative nursing he nurses note a decline or if a they are supposed to inform hanges. The PTA-A stated the ot informed her R66 had not The PTA-A also stated she he staff were unable to rative nursing due to staffing d "I see them running around y busy here". 11/20/14 at 11:44 a.m. (PT)-A was observed to ne hallway by the dinning room or and transfer belt 130 feet, the not had a decline in her				
	had hypertension a impaired needed a	and was moderately cognitively ssist of one to walk in corridor and a wheelchair. R73's CAA				

If continuation sheet Page 26 of 61

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	12/29/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
		245513	B. WING		11/2	20/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO		10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 311	with all ADL's due to dementia. The CA attending PT and C little progress. R73's care plan da received restorative promote his ability to the highest level was to ambulate with rolling walker 200 f nursing assistant c ambulate with rollin with w/c (wheelcha feet or as tolerated A Physical Therapy indicated he was re- improvement in me recently by therapy improvement. The ambulates with sho base of support an The facility HCFA 7 indicated "PT was exercise with nursi remain long term c contact guard assis assist] and a rolling theraputic exercise equipment], transfe gait training". R73's Restorative 1 04/09/14, intimated	cated he needed assistance to Parkinson's Disease and A further indicated he is DT services but making very ted 2/25/14, indicated he e nursing ambulation to to maintain or restore function of physical functioning. R73 ith assistance of one and eet or as tolerated. R73's are sheet indicated he was to ng walker and assist of one ir) to and from meals and 100 BID (twice a day).	F 311			

If continuation sheet Page 27 of 61

		AND HUMAN SERVICES			FORM	12/29/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING			E SURVEY PLETED
		245513	B. WING		11/2	20/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO		10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 311	Continued From pa	age 27	F 311			
	dated October 201 200' (feet) five out increase in a antipa antidepressant me	ive Nursing Monthly Review 4, indicate "Resident walked of 26 days. Resident did have arkinson's medication and dication 10/08. Resident ng fair. Will continue POC				
	0	11/20/2014, at 4:50:21 PM bed watching television.				
	The Point of Care I	History indicated the following:				
	opportunities, refuse condition 8 times.	ambulated 14 times out of 60 sed 3 times, deferred due to The history did not indicate the d not ambulate the remaining				
	opportunities, refuse and deferred due to	oulated 21 times out of 62 sed once, not observed 8 times o condition 7 times. The cate why he did not ambulate mes.				
	opportunities, refuse condition 8 times.	mbulated 14 times out of 60 sed 3 times, deferred due to The history did not indicate nbulate the remaining 35				
	stated he has not b	/20/14, at 10:45 a.m. PTA-A been referred to see R73 and when he was seen by therapy				

Facility ID: 00714

If continuation sheet Page 28 of 61

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUP		A. BUILDING	E CONSTRUCTION	(X3) DATE SUR COMPLET	
	PLIER				ED
				11/20/2	014
LAKE RIDGE CARE CEN			TREET ADDRESS, CITY, STATE, ZIP CODE		
			10 LAKE BOULEVARD BUFFALO, MN 55313		
	RY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX (EACH DEFIC	CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE CON	MPLETION DATE
F 311 Continued Fro	om page 28	F 311			
she had arthri ambulated wit and used a wa dated 04/17/1 due to needing attended PT a highest level o program in pla R42's care pla alteration in m ambulates per one and walke A Therapy Ass REHAB dated with a rolling v SBA and CGA	an dated 6/28/14, indicated she had obility related to weakness and r restorative program assistance of				
initiated by PT	ursing Program dated 10/19/11, A-A indicated walking program feet with rolling walker, transfer belt mes a day.				
10/21/14, india days out of 30 less than 100 at least 50% of tolerates well reflect residen for further deta the program w Nursing Progr	tive Nursing Monthly Review dated cated R42 ambulated 100 feet 25 . Resident continues to ambulate feet and is not completing daily but of days in the past month she changed to qod (every other day) to its current progress see care plan ails. Although the note indicated vas changed, the Restorative am did not identify the changes. ation 11/20/2014, at 4:56 p.m. R42				

Facility ID: 00714

If continuation sheet Page 29 of 61

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM /	12/29/2014 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL			E SURVEY PLETED
		245513	B. WING		11/2	20/2014
NAME OF I	PROVIDER OR SUPPLIER		S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
LAKE RI	DGE CARE CENTER	OF BUFFALO		I0 LAKE BOULEVARD UFFALO, MN 55313		
	SI IMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORREC		(25)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 311	Continued From pa	age 29	F 311			
	indicated she is wa supper. At 5:00 p. was observed to ta	ng in dayroom by the elevator iting to go down stairs for m. nursing assistant (NA)-K ke R42 in her wheelchair into g down stairs and was not				
	who verified R42 deprogram as identified	/19/14, at 9:08 a.m. NA- B oes not receive her ambulation ed, because they are short possible to get her work done.				
	Review of the Poin following:	t of Care History indicated the				
	opportunities, not c information was do	ambulated 35 times out of 60 observed twice and no cumented once. The history y R42 did not ambulate the s.				
	times, and informa	oulated 34 times out of 62 tion 14 times. The history did 42 did not ambulate the 5.				
	no information 8 tin	mbulated 22 times out of 60, nes. The history did not id not ambulate the remaining				
	stated she was the today for 13 reside NA's on her unit. N least once a week sometimes the resi	/19/14, at 9:01 a.m. NA- D only one working on her unit nts and they should have two IA-D stated this happens at and because of that torative nursing programs can ts rehab program completed.				

If continuation sheet Page 30 of 61

		AND HUMAN SERVICES			FORM	12/29/2014 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING			E SURVEY PLETED
		245513	B. WING		11/2	20/2014
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE <b>10 LAKE BOULEVARD</b>		
LAKE RI	DGE CARE CENTER	OF BUFFALO		SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 311	Continued From pa	age 30	F 311			
	verified the Restor be completed twict the restorative nurs given to the clinical responsible to let u declining or not pa PTA-A stated she w nursing programs should. During interview 1 <sup>4</sup> PT-A stated the the initiate the nursing coordinators are in program and the of oversees the program nursing staff are to participating, has a fall. The PT stated restorative program During interview 1 <sup>4</sup> stated there have 1 just isn't enough st programs and there the floor and know The DON further s assistance have be nursing programs policy for the program During interview 1 <sup>4</sup> coordinator register nursing assistance restorative nursing	<ul> <li>J/20/14, at 10:51 a.m. PTA-A ative Nursing Program should a a day. PTA-A also indicated sing rehab program sheet is I coordinator and they are as know if the resident is rticipating in the program. The was aware the restorative were not being completed as it</li> <li>J/20/14, at 11:25 a.m. with erapists work with nursing and rehab program. The clinical charge of the restorative director of nursing (DON) ram. The PT-A stated the inform us if a resident is not a decline or has an injury with a d they were not being done.</li> <li>J/20/14, at 12:05 p.m., the DON been some days where there aff to complete the restorative e are days she was working on s it just can not get completed. tated all of the nursing een trained in the restorative and they do not have a specific am.</li> <li>J/20/14, at 1:50 p.m. the clinical red nurse (RN)-D stated the are to complete there and that she was not informed to complete there programs.</li> </ul>				

If continuation sheet Page 31 of 61

		AND HUMAN SERVICES		FORM	: 12/29/2014 APPROVED . 0938-0391
-	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		E SURVEY IPLETED
		245513	B. WING	11/	20/2014
	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE R	DGE CARE CENTER	OF BUFFALO	B	UFFALO, MN 55313	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From pa	age 31	F 311		
F 312 SS=D	for the nurses and Restorative Nursin materials indicated restorative nursing by the nurse and for able to do the prog program found in y personal data shee program including to do them can be Coordinator can an have about the pro- the resident is una program. Once yo program for your re bottom of the shee the restorative nurs to be in compliance you do have an ob 483.25(a)(3) ADL ( DEPENDENT RES A resident who is u daily living receives maintain good nutr and oral hygiene. This REQUIREME by: Based on observa- review, the facility for 2 of 3 residents	CARE PROVIDED FOR	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

Facility ID: 00714

	-	H AND HUMAN SERVICES				FORM	12/29/201 APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		E SURVEY PLETED
		245513	B. WING			11/2	20/201 <u>4</u>
NAME OF F	PROVIDER OR SUPPLIE				REET ADDRESS, CITY, STATE, ZIP CODE 0 LAKE BOULEVARD		
LAKE RI	DGE CARE CENTE	R OF BUFFALO		-	JFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 312	Continued From p	bage 32	F 3	12			
	Findings include: R121's admission 9/17/14, indicated needed limited as bathing and groon 10/15/14, indicate all ADL's (activitie one for weekly ba	n minimum data set (MDS) dated d she was cognitively intact and ssist of one with dressing, ming. R121's care plan dated ed she needed assistance with ss of daily living) and assist of			admission that a deficiency exists one was cited correctly. The Plan Correction is submitted to meet requirements established by State Federal law. It is the policy of Lake Ridge Care to provide routine bathing to resid continue good personal hygiene. To assure continued compliance,	e and e Center ents to	
	assistant (NA)- D staffed. Baths and as they are scheo sheets which indi- signed off as give	stated the facility was short d showers are not getting done duled. NA-D provided the bath cated R121's bath was not en. NA-D stated we "were affed and the bath didn't get			following plan has been put into p 1. Regarding cited residents: Although one resident is no longe facility, the other resident has and continue to receive routine bathin continue good personal hygiene.	lace; r in the l will	
	stated she just re and had not gotte 11/14/14, she stat give me my bath so I guess I can ta	11/19/14, at 11:59 a.m. R121 turned to the facility on 11/7/14, on her bath that week nor on ted "The staff never offered to and I am going home on Friday ake a bath when I go home. It o weeks since I took a bath".			2.Actions taken to identify other p residents having similar occurrent All residents that receive bathing and will be evaluated to continue routing bathing to continue good p hygiene.	ces: have receiving personal	
	director of nursing unable to give a b it so the next shift	11/20/14, at 12:00 p.m. the g (DON) stated if the staff are bath they are supposed to report t can give it. The DON verified documented as given.			3.Measures put in place to ensure deficient practice does not recur: Bathing will be scheduled and foll and each resident will receive at le full body bath once per week and recorded on the bath sheet by the and nursing assistant. If a resider refuses or is not available for their	owed east one will be nurse nt	
	intact cognition, a assistance of one (CP) for R22, date	DS, dated 10/28/2014, indicated and further that she required the for bathing. The care plan ed 6/12/2014, identified an sing, grooming, and bathing			scheduled weekly bath, a make-u will be scheduled with the residen mutually agreed upon time with a and will be documented by that nu to having been refused and/or una	p bath t at a nurse urse as	

Facility ID: 00714

		RE & MEDICAID SERVICES			<u>/IB NO. 0938-03</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		11/20/201 <u>4</u>	
NAME OF F	PROVIDER OR SUPPLIE	R		TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RII	DGE CARE CENTE	R OF BUFFALO	-	10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	FION SHOULD BE THE APPROPRIATE CY)	
F 312	Continued From	page 33	F 312			
	related to weakn	ess. The CP included the ist of 1 for weekly bathing" for		and was rescheduled on the bath sh	neet.	
	R22.			<ol> <li>Effective implementation of action be monitored by:</li> </ol>		
	resident was not	on on 11/17/2014 at 2:16 p.m. ed to be dressed for the day, d and adjusting an earring.	,	Each unit nurse will be responsible monitoring that bathing is done for e resident on that unit and that will be	each	
		ew on 11/18/2014 at 1:39 p.m. presently gets one shower a	,	confirmed by signing the bath sheet each weekly bath. Those bathing documents will be reviewed weekly		
	Sometimes they' enough staff on t	I "I'm lucky I get even that. re too busy. They did not hav o help me." R22 went on to s		Director of Nursing for compliance f three months, and then monthly. Performance on the effectiveness o	f	
	came into the nu	ver for almost 2 weeks when I rsing home near the end of stated that her family stepped weekly shower."	in,	completed bathing schedules will be presented to the QAPI committee for consecutive quarters for continued compliance.		
	bathing, indicated 5/31/2014, then a document indicated	t of Care History" for R22's d she had a shower on again on 6/13/2014. The ted that on 6/7/14 and 6/12/14		5.Those responsible to maintain compliance will be: The Director of Nursing or designee be responsible for maintaining comp	oliance	
	indication R22 ha 5/31/14 and 6/13	artial" bed baths. There was nad received a shower between /2014. A review of "Bath Day s for R22 indicated 6/13/2014 n record for her.		of routine bathing being completed. Completion date for certification pur only is: December 22, 2014		
	registered nurse shower was give	ew on 11/20/2014 at 2:33 p.m. (RN)-D said when a bath or n, "it is recorded in Matrix (a m) or on a resident's body aud				
	sheet." RN-D co	uld not determine if R22 had a 31/14 and 6/13/2014.				
F 314	was provided.	policy was requested, but non	e F 314		12/22/14	

If continuation sheet Page 34 of 61

		AND HUMAN SERVICES			PRINTED: 12/29/2014 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245513	B. WING		11/20/2014
NAME OF F	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	
	DGE CARE CENTER			310 LAKE BOULEVARD	
	DOE OARE OERTER	or Borraco	I	BUFFALO, MN 55313	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 314	Continued From pa	34	F 314		
SS=D			F 314		
55-D	FREVENI/HEAL F	RESSURE SORES			
	resident, the facility who enters the facility does not develop p individual's clinical they were unavoida pressure sores rec	brehensive assessment of a a must ensure that a resident lity without pressure sores pressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and from developing.			
	by: Based on observa review the facility fa interventions of a c buttock and preven for 1of 3 residents for pressure ulcers Findings include: R18's PPS 5 day a (MDS) dated 11/11, at high risk for skin weakness from res assist of two person two persons for bea R18's care plan for indicated " potentia seizures, decrease arthritis, recent CV of stasis ulcers( op circulation) and Pa	assessment Minimum Data Set /14, indicated intact cognition, breakdown, left sided idual affects of recent stroke, on for transfers and assist of d mobility. r skin integrity dated 10/14/14 I in skin integrity related to d mobility due to recent A (left sided weakness) history en areas from poor venous rkinson's disease. At risk for		<ul> <li>F314-D</li> <li>This Plan of Correction constitute written allegation of compliance f deficiencies cited. However, sub of this Plan of Correction is not a admission that a deficiency exists one was cited correctly. The Pla Correction is submitted to meet requirements established by State Federal law.</li> <li>It is the policy of Lake Ridge Carr that we monitor and assess inter of current pressure ulcers and pr pressure ulcer reoccurrence in reidentified as a high risk for press ulcers.</li> <li>To assure continued compliance following plan has been put into p 1. Regarding cited residents:</li> </ul>	for the omission in s or that n of te and e Center ventions revent esidents ure , the place;
	pressure ulcers/ sk	in breakdown/injury. Avoid hkle and encourage resident to		The resident will continue to have monitoring and assessment of cu	

Facility ID: 00714

If continuation sheet Page 35 of 61

CENTER		TH AND HUMAN SERVICES RE & MEDICAID SERVICES			FORM APPRO OMB NO. 0938-0		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245513	B. WING	- ETN /	11/20/2014		
NAME OF I	PROVIDER OR SUPPLIE	R		TREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE RI	DGE CARE CENTE	R OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLÉT		
F 314	Continued From	page 35	F 314				
		It leg up on pillow (elevation to Skin checks are to be performed beded. "		skin issues to prevent the potent reoccurrence of a pressure ulcer			
	During observation p.m., R18 was ob bed was flat. R18	on of R18 on 11/19/14 at 2:01 oserved lying on his back head of 3's was head supported with one ow support was provided for his		2.Actions taken to identify other presidents having similar occurrer All residents have and will contin have skin monitoring and assess completed with their weekly bath prevent potential pressure ulcer reoccurrence.	nces: ue to sment		
	licensed practica 2:53 p.m., R18 w shiny/reddened a centimeter lengt buttock proximal open area. Barrie area. R18 legs w	on of personal cares with I nurse (LPN-A), on $11/20/14$ at vas incontinent of urine and had a area that was approximately 1.5 h x 0.5 centimeter width on right to gluteal crease, there was no er cream was applied to entire ere dry and flaky skin but there pressure or open areas on his		3.Measures put in place to ensur deficient practice does not recur: Thorough inspections of skin inte be done with all new admissions returns and along with weekly ba the nurse of that unit on the Skin Assessment Audit form. Any pot skin issues will be communicated Clinical Coordinator and Director Nursing so assessment can be n	egrity will , hospital , hospital , thing by cential d to the of nade,		
	3:14p.m., R18 w feet covered by b elevation of feet. (LPN-A) confirme a pillow. The fac assignment shee CENTER CARE R18's feet should 10/14/14 care pla	on of R18 on 11/20/14 at yas in bed with HOB elevated and olankets without a pillow or Licensed practical nurse ed R18's feet were not floated on cility nursing assistant et titled LAKE RIDGE CARE SHEETS undated did not identify d be elevated as identified by the an.		<ul> <li>care plan updating can be completed interventions can be put to prevent further breakdown or progression of wounds.</li> <li>4.Effective implementation of act be monitored by:</li> <li>The Director of Nursing will colleted monitor the Skin Assessment Au monthly for continued compliance follow-up for six months. The Director skin assessment statement and the skin assessment statement of the skin assessment statement o</li></ul>	in place tions will ct and dit forms e and rector of		
	11/4/14 at 1:15 p from St. Cloud H spoke with RN at shift. Resident w at approximately	.m., indicated communication ospital that identified, "Writer t St. Cloud Hospital this a.m. ill be returning to LRCC [facility] 12:00 or 1:00 pm this shift. ht ankle, and a little open area		monitoring compliance to the QA committee for two quarters. Furt for monitoring will be evaluated b QAPI committee. 5.Those responsible to maintain	NPI ther need		

Facility ID: 00714

STATEMENT	RS FOR MEDICAL	RE & MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
	PROVIDER OR SUPPLIE		3	STREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD BUFFALO, MN 55313	11/20/201 <u>4</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLET
F 314	under abdominal approximately 1: this shift." There was a note EVALUATION da from surgery on a and slit on abdom there was an ope was identified by 11/4/14, there wa ankle." R18's had a curre identified nursing right open area of AG (a dressing s and change dress Review of the fac PHYSICAL SKIN 11/19/14 indicate right gluteal fold length x 1cm wid Review of facility reviewed from 11 indication that R4 right ankle or but During interview examined the ski had been no ass to monitor the pro or right ankle. LP open area to her	fold. Resident arrived at 20 pm from St. Cloud Hospital e titled PHYSICAL SKIN ated 11/4/14 identified, sutures eff hip, multiple sites of bruising, nen. There was no indication en area to the right ankle, which the nursing progress note on as an, "open area on right ent physician order dated 11/5/14 staff to perform wound care to in medial ankle. Apply Mepilex pecific to this open area) border sing every other day. cility medical record identified a EVALUATION form dated d R18 had an open area on his which was 4 cm (centimeters) in dth. There was no depth listed. bath audits for R18's were /4/14 to 11/19/14. There was no 18 had any open areas on R18's tock area. on 11/20/14 at 2:55 p.m. LPN-A in audits and confirmed there essments or tracking completed essure ulcers on R18's buttock N-A stated she would report any supervisor and see if new orders such as a nutritional supplement	F 314	compliance will be: The Director of Nursing or des responsible for maintaining the compliance of monitoring and a of skin issues. Completion date for certificatio only is: December 22, 2014	assessment

If continuation sheet Page 37 of 61

CENTE STATEMENT	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	FORM OMB NO. (X3) DATE	12/29/2014 APPROVED 0938-0391 E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED
		245513	B. WING	FIN	11/:	20/201 <u>4</u>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO		B10 LAKE BOULEVARD BUFFALO, MN 55313		
				•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	Even though R18 f ankle, when he ret on 11/5/14, and a p his buttock area. T area were consister monitored to preve from developing. During interview or director of nursing aware of any press She confirmed the event part of our pr notes about the pre clinical coordinator the care plans and residents' cares. T required to docume	age 37 nad a pressure ulcer on his urned from his hospitalization pressure ulcer on 11/19/14 on here was no indication these ently measured, assessed and ant additional pressure ulcers n 11/20/14 at 5:02 p.m., the (DON) stated she was not sure ulcers for this resident. re were nothing noted in the point click care nor any progress essure ulcers. She stated the s are responsible for updating nursing staff on changes for he coordinators are also ent weekly skin audits which d weekly. The DON confirmed	F 314			
	and consistently m Policy Titled PRES DOCUMENTATION 2014 indicated that audits done weekly pressure ulcer is n assignment sheet Policy Titled WOUN TREATMENT- Elin indicated that nurs weekly on the appre either using the pre form or the skin inj injuries not related preventative meas using devices that	SURE ULCERS N - Elim Care revised June t all resident will have skin / by a licensed nurse. If a oted the nurse aide				

If continuation sheet Page 38 of 61

CENTER	<u>RS FOR MEDICAE</u>	RE & MEDICAID SERVICES		OMB N	<u>O. 0938-039</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		1/20/2014	
NAME OF I	PROVIDER OR SUPPLIE	R	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			. 31	10 LAKE BOULEVARD		
LAKE RI	DGE CARE CENTE	R OF BUFFALO	В	UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIOI DATE	
F 314	Continued From	page 38	F 314			
	pressure and imp	prove body alignment.				
F 315 SS=D	483.25(d) NO CA RESTORE BLAD	THETER, PREVENT UTI, DDER	F 315		12/22/14	
	assessment, the resident who entri- indwelling catheter resident's clinical catheterization w who is incontinen- treatment and se	ident's comprehensive facility must ensure that a ers the facility without an er is not catheterized unless the condition demonstrates that as necessary; and a resident it of bladder receives appropriate rvices to prevent urinary tract restore as much normal bladder ble.				
	by: Based on observer review, the facility assistance for toi reviewed for uring Findings include: R91's admission 9/26/14, identified impairment, was and required exter complete toileting During continuou 11/20/14 at 1:42 in bed with her ev (NA)-C entered to observed R91, her	Minimum Data Set (MDS), dated d R91 had severe cognitive frequently incontinent of urine, ensive assistance of two staff to		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.	r	

Facility ID: 00714

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED
		245513	B. WING		11/2	20/201 <u>4</u>
NAME OF F	PROVIDER OR SUPPLIE	R	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTE	R OF BUFFALO		10 LAKE BOULEVARD		
			В	UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 315	Continued From	page 39	F 315			
	range of motion ( to check R91 for R91 had been into offered help/assis incontinence card during the contin NA-C stated she toileting or incont hours and 3 minut stated R91 shoul every two hours. Review of R91's assessment, data always incontinent functional inconti to the toilet per s required assistant ask for toileting a participate in a to checked for incon needed) every 2 Review of R91's identified she was bladder, and was defecate. The ca how often to assis even though the hours to assist w Review of R91's indicated R91 was	ROM) exercises. NA-C offered incontinence at 4:03 p.m., and continent of urine. NA-C had not st R91 to toilet or with e for 2 hours and 21 minutes uous observation. At 4:03 p.m., had last assisted R91 with inence care at 1:00 p.m. (3 utes) because of staffing. NA-C d be checked for incontinence Nursing Observations ed 9/26/14, indicated she was not of urine, and suffered from nence (caused by inability to get elf or in a timely fashion). R91 uce with toileting, was unable to issistance, was unable to issistance, was unable to issistance, was unable to issistance and changed (if hours. care plan, dated 10/9/14, s incontinent of bowel and a unaware of the need to void or are plan lacked an indication for st her with incontinence care assessment identified every two ith toileting//incontinence care. un-dated Resident Care Sheet is frequently incontinent of bowel should be, "C&C [checked and		<ul> <li>residents having similar occurre Care plans for all residents hav reviewed and revised as needed appropriate interventions and ti for staff to adequately provide for our resident is needs.</li> <li>3.Measures put in place to enside deficient practice does not recurred Care assignment sheets will re- reviewed and revised resident of so that residents can be toileted timely manner.</li> <li>4.Effective implementation of a be monitored by: We will be directly observing to schedules and will be interview residents on scheduled toileting the care assignment sheets ha reflected toileting in a timely ma- will monitor two residents once in this fashion, and those findin placed on the 2014 POC Audit sheet. A summary of these dire observations and interviews will submitted to the QAPI committed quarterly meetings.</li> <li>5.Those responsible to maintait compliance will be: The Director of Nursing or desite responsible to maintain compliant timely assistance for toileting of the set of the toileting of the set of the toileting of the set of the tomaintain compliant</li> </ul>	re been ed, with metables for each of ure ir: flect the care plans d in a ctions will ileting ing g to confirm ve properly anner. We per week gs will be Form ect I be ee for two n gnee is ance with f residents.	
	When interviewe registered nurse	d on 11/20/14 at 4:14 p.m., (RN)-C stated the information e Sheet(s) was accurate, and		Completion date for certification only is: December 22, 2014	n purposes	

		AND HUMAN SERVICES		FORM	: 12/29/2014 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		E SURVEY IPLETED
		245513	B. WING	— <b>—</b> — <b>—</b> 11/	20/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD	
LAKE RI	DGE CARE CENTER	OF BUFFALO		UFFALO, MN 55313	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 315	Continued From pa	age 40	F 315		
	staff should be che every 2 hours.	cking R91 for incontinence			
		n 11/20/14 at 4:21 p.m., RN-A be checked for, and assisted care every 2 hours.			
		on 11/20/14 at 4:41 p.m., the (DON) stated cares listed on ould be followed.			
F 318 SS=E	requested, but non	EASE/PREVENT DECREASE	F 318		12/22/14
	resident, the facility with a limited range appropriate treatm	prehensive assessment of a y must ensure that a resident e of motion receives ent and services to increase id/or to prevent further of motion.			
	by: Based on observa review, the facility rehabilitative servic ordered for 4 of 4 r R5) who received r	NT is not met as evidenced tion, interview and document failed to provide nursing ces for range of motion as residents (R18, R66, R42, and range of motion (ROM) through ces to maintain or increase OM).		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.	

Event ID: GGOI11

Facility ID: 00714

If continuation sheet Page 41 of 61

CENTER	RS FOR MEDICA	TH AND HUMAN SERVICES RE & MEDICAID SERVICES		ON	FORM APPROVE 18 NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		X3) DATE SURVEY COMPLETED
		245513	B. WING		11/20/201 <u>4</u>
VAIVIE OF F	PROVIDER OR SUPPLIE			TREET ADDRESS, CITY, STATE, ZIP CODE	
AKE RI	DGE CARE CENTE	R OF BUFFALO		10 LAKE BOULEVARD SUFFALO, MN 55313	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 318	Continued From	nage 41	F 318		
1 010	Continued From		1 510		
	R18's PPS 5 da	y assessment minimum data set		It is the policy of Lake Ridge Care C	enter
		11/14, indicated intact cognition,		that nursing rehabilitative services a	
	left sided weakne	ess from residual affects of		provided to maintain or increase ran	
		ssistance of two persons for bed		motion (ROM).	-
		sist of two persons for transfers			
	from bed to whee	elchair.		To assure continued compliance, the	
				following plan has been put into plac	;
		re plan updated for activities of			
		6) 10/25/14 indicated he is at		1. Regarding cited residents:	
		cline related to recent stroke		The residents cited have had their R	
		and generalized weakness.		programs adjusted to be provided m	
		he care plan were one assist for		consistently to maintain or increase ROM.	their
		ng required 1-2 persons was to changes in ADLS and a need for		ROWI.	
		therapy evaluation.		2.Actions taken to identify other pote	ontial
	an occupational			residents having similar occurrences	
	During observati	on of morning cares on 11/19/ 14		All residents who have been reviewe	
		8 required three persons to		may benefit from a ROM program have	
		nobility and transfers from bed to		had their ROM programs adjusted to	
		did not not use arms or legs to		provided more consistently to mainta	
		ecessary to complete		increase their ROM.	
	•	e in bed including hygiene. At			
		orning cares NA-E stated [R18]		3.Measures put in place to ensure	
		restorative program for upper		deficient practice does not recur:	
		ange of motion. "We do		A policy has been written regarding	ROM
		each of our group (group of		programs. Nursing will identify all	
		prative program) ". NA-E moved		residents who may benefit from a R	
		egs in tandem while dressing		program on admission, as needed,	
		d when we complete overhead		discharge from therapy and on a qu	
		ave clothing placed such as		basis. When a resident starts a RO	
		this counts as a restorative		program, the care plan will be updat	
		movements we do that are		along with a 2014 POC Audit Form s The nurse of the unit will monitor the	
	necessary to dre	33 a 153105111.		program for their residents and will b	
	NA-R was also n	resent during the observation,		responsible to make sure that nursir	
		essing [R18] was sufficient as		assistants are completing the ROM	·ອ
		rogram for R18. NA-B stated		programs per the goals of the care p	olan.
		ecific number of repetitions and it		Activities programming includes 3-5	

Facility ID: 00714

If continuation sheet Page 42 of 61

STATEMEN	OF DEFICIENCIES	RE & MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION (X3) D	O. 0938-039 ATE SURVEY OMPLETED
NAME OF	PROVIDER OR SUPPLIE	<b>245513</b> R		TREET ADDRESS, CITY, STATE, ZIP CODE	1/20/201 <u>4</u>
LAKE RI	DGE CARE CENTE	R OF BUFFALO	-	UFFALO, MN 55313	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 318	is done to complemark it as a comprestorative sessionalso showed the CARE CENTER performed with e contained " activeright side and parside ". The care is body parts, types motion, or numb During chart reviemation, or numb During an interviemation charting with e director nursi the nursing assisses resident are respected electronic resident treatmer and R18 should the morning cares. "It caseload they wor nursing." R18's lawas discharge shown floor should be at ROM program. Not dressing in the minematication of the minematication of the morning care floor should be at ROM program. Not dressing in the minematication of the minema	ete the task of dressing. We pleted range of motion on in the restorative book. NA-E surveyor her LAKE RIDGE RESIDENT CARE SHEET care ach resident for R18 it re range of motion to (R18s) ssive range of motion to his left sheet did not contain specific of exercises listed for range of er of repetitions to be performed. we active range of motion from it was documented not s out of 7 days in the electronic ick care. Passive range of was requested but not provided.	F 318	<ul> <li>facility exercise programs weekly on a routine basis, which include exercises for both upper and lower extremities.</li> <li>Activities will update nursing if residents involved in these programs are no longer attending or actively participating so programs can be adjusted.</li> <li>4.Effective implementation of actions will be monitored by:</li> <li>Monitored and completed 2014 POC Au 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 quarter meeting for two quarters, and then as needed at the discretion of the QAPI committee.</li> <li>5.Those responsible to maintain compliance will be: The Director of Nursing or designee will be responsible for maintaining complian with nursing rehabilitative services for ROM.</li> <li>Completion date for certification purpose only is: December 22, 2014</li> </ul>	r I dit ss ie Iy

If continuation sheet Page 43 of 61

STATEMENT	OF DEFICIENCIES OF CORRECTION	RE & MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIE		B. WING STREET ADDRESS, CITY, STATE, ZI 310 LAKE BOULEVARD		11/20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FFALO, MN 55313 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC	
F 318	assistant would b part 10-15 repeti as ROM needs to During an intervie the physical thera occupational thera occupational thera we hand off the r coordinator (RN put on care shee clinical coordinat for a specific pro Expectations are program for R18 performed by the does not meet th therapy staff mer with the resident understand the p range of motion of would be the exp alone should not R18's restorative 11/17/14 was rev program listed: I passive range of resident slowly th range of motion of through the arc of to use seated ex arm bike for his r of motion. The P range of motion for joint and muscle repetitions would performed. Rang 10 repetitions for	be expected to move the body tions. Dressing does not count be continuous repetitions. ew on 11/20/14 at 9:41 a.m., with apist assistant ( PTA)-A and rapist assistant ( PTA)-A and rapist assistant (OTA)-A stated, estorative program to the clinical in charge of the unit) and they ts and deal with it from there. If or has a concern or a question gram they contact us again. that a current restorative would be daily, 7 x/week and e nursing staff. If a program e staff or resident's needs then a nber would come up and work and nursing staff until all parties rogram. "Repetitions in the (ROM) for (R18's) his ability pectation for ROM and dressing				

If continuation sheet Page 44 of 61

		AND HUMAN SERVICES	1		FORM	12/29/2014 APPROVED 0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING			E SURVEY PLETED
		245513	B. WING		11/2	20/2014
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	-	10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETION DATE
F 318	Continued From pa	age 44	F 318			
		stated , R18 would lose range				
		tion, transfer ability and LS of ROM is not consistently				
		ng should not be used alone				
	state, "I don't reme me with with stretcl	on 11/20/14 10:59 a.m., R 18 mber the last time they helped hing (range of motion) to my ey did in therapies."				
		ed to provide R18 consistent designated in the restorative				
	9/30/14, included d severe cognitive im upper (UE) and low R66's care plan da	ted 10/14/14, indicated she				
	(active range of mo resident's ability to	ive nursing program, AROM otion) daily to promote the maintain or restore function to physical functioning.				
	Monthly Review da was at risk for ADL and condition. The AROM goal was m own hair, apply ma	I nurse) Restorative Nursing ted 10/28/14, indicated R66 decline related to diagnosis Review indicated R66's et and to continue to comb keup, and had some refusals dition in last 30 days but to re.				

		AND HUMAN SERVICES			FORM	12/29/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING			E SURVEY PLETED
		245513	B. WING		11/:	20/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO		10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 318	FORM Occupation indicated R66's Oc discontinued due to cellulitis to hand. T (resident) DC (disc hosp with possible res was not particip 2 sessions and new cues to participate She was able to pr (skilled nursing fac however did use U occasion or when of was discontinued of identify if restorative implemented or no Review of the Rest 2/14/14 which was therapy assist (PTA to UE (upper extreme once a day. Review of Point of following: September 2014-ARC 31 opportunities, d times and not obset History did not indi- AROM the remaini November 1st thru	Therapy Assessment 701 al Therapy form dated 7/22/14, cupational Therapy (OT) was b hospitalization with possible The form identified "Res continued) rx (treatment), dc to cellulitis to hand. At time of dc bation with therapy refused last eded max verbal and tactile the other dates of service. opel wc short distances in SNF ility) using LE (lower extremity) E (upper extremity) on cued to do so." Although OT on 7/22/14, the form did not e nursing program was to be t. torative Nursing Program dated recommended by physical A)-A indicated AROM program mity) and LE (lower extremity) Care History indicated the AROM completed 30 times out OM completed 16 times out of eferred due to condition three erved twice. The Point of Care cate why R66 did not receive ng 10 opportunities. November 19th 2014- AROM	F 318			
	November 1st thru completed 10 time	2				

If continuation sheet Page 46 of 61

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	12/29/2014 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE COMF	E SURVEY PLETED
		245513	B. WING		11/2	0/2014
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO		10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	τιον	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
F 318	Continued From pa	age 46	F 318			
	not receive AROM	the remaining 9 opportunities.				
	was observed to be down the hall indep	11/19/14, at 12:00 p.m. R66 e in her wheelchair wheeling pendently, there was no recieved her AROM excercise				
	stated they are sho	/19/14, at 9:05 a.m. NA- D ort staffed and she is unable to n R66 a lot of the time due to time.				
	stated she was not receiving her AROI care. OT-A further are supposed to let	/20/14, at 11:25 a.m. OT-A aware that R66 was not M according to her plan of stated the clinical coordinators t therapy know if residents are re programs and they had not				
	OT-A was observe	11/20/14, at 11:50 a.m. the d to provide AROM with R66 dent remained unchanged and II ROM.				
	was cognitively inta anemia. The MDS extensive assist of impairment on ons impairment on her indicated she need due to multiple diag attended PT and O	OS dated 9/16/14, indicated she act, had hypertension and further indicated she needed one with ADL's and had ide of her UE and no LE. R42's CAA dated 4/15/14, led assistance with all ADL's gnosis including arthritis. Has IT in the past and was at her ction, restorative program in				

Facility ID: 00714

If continuation sheet Page 47 of 61

		HAND HUMAN SERVICES E & MEDICAID SERVICES			FORM	12/29/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245513	B. WING		11/:	20/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO		B10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 318	Continued From pa	age 47	F 318			
	R42's care plan da received AROM to or restore function functioning. The c AROM to UE and I include seated leg gripper or squeeze The Therapy Asse dated 09/06/13, co received OT five th and met goals with motivation and no and was discontinu and participate on program as tolerat Restorative Nursin indicated she was 15 minutes daily. RN Restorative Nut 10/21/14, indicated was to dress uppe The summary of or appropriate. Staff a goal to a more app complete AROM p fair to good. The s had no changes in since last review. The Point of Care September 2014- A opportunities. The AROM several tim	ted 10/21/14, indicated she promote her ability to maintain to the highest level of physical are plan indicated she needed LE daily for 15 minutes may exercises, thera-band, hand a ball. ssment Occupational Therapy impleted by OT, indicated she mes a week for 23 sessions a bilateral UE she has low longer required OT services ued. R42 was to stay long term nursing restorative and walk ed. g Program dated 10/19/11, receive AROM to UE and LE arsing Monthly Review dated d no need for OT referral and r extremity with set up assist. f the goal indicated goal not assist with dressing change propriate one does continue to rogram daily tolerates program summary also indicated she her ROM voluntary movement History indicated the following: AROM 29 out of 30 history indicated R42 received				

If continuation sheet Page 48 of 61

		(X2) MULTIPLE A. BUILDING _	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NT OF DEFICIENCIES	
11/20/2014	ET ADDRESS, CITY, STATE, ZIP CODE	B. WING	<b>245513</b> ER	F PROVIDER OR SUPPLIE	NAME OF F
	AKE BOULEVARD FALO, MN 55313		ER OF BUFFALO	RIDGE CARE CENTE	LAKE RII
TION SHOULD BE COMPLETION THE APPROPRIATE DATE	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	ID PREFIX TAG	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	(EACH DEFICIEN	(X4) ID PREFIX TAG
		F 318	page 48 o information was documented oformation was provided why R42 ROM the remaining 14 times. - received AROM 19 out of 19 11/19/14, at 9:07 a.m. NA- B 2 does not receive her AROM that she should and when they it is impossible to get her work DS dated 10/07/14, indicated she rder and hypertension. The MDS she was cognitively intact and e assist of two with dressing, and onal hygiene and had no er UE and LE. R5's care area A) dated 10/07/14, indicated she ce with ADL's (activity of daily akness related to osteoarthritis	<ul> <li>opportunities, no five times. No intidid not receive All November 2014-opportunities.</li> <li>During interview who verified R42 consistently and are short staffed done.</li> <li>R5's quarterly MI had seizure disor further indicated a needed extensive assist with person impairment on he assessment (CA needed assistant)</li> </ul>	F 318
			ated 08/05/14, indicated she n dressing, bathing and grooming one to two with all ADL's. The ed she received AROM. rapy note dated 10/26/11, ceived OT for limited UE ROM	R5's care plan da needs assist with needs assist of o care plan indicate Occupation Thera indicated she rec	
			er UE and LE. R5's care area (A) dated 10/07/14, indicated she ce with ADL's (activity of daily akness related to osteoarthritis hest level of functioning. ated 08/05/14, indicated she n dressing, bathing and grooming one to two with all ADL's. The ed she received AROM. rapy note dated 10/26/11,	<ul> <li>impairment on he assessment (CA, needed assistant)</li> <li>living) due to wea and is at her high</li> <li>R5's care plan da needs assist with needs assist of o care plan indicate</li> <li>Occupation Thera indicated she rec and fatigued easi upper body dress dressing. The normalized she recomplete the she r</li></ul>	

If continuation sheet Page 49 of 61

		AND HUMAN SERVICES			FORM	12/29/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		245513	B. WING		11/2	20/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RIE	OGE CARE CENTER	OF BUFFALO		310 LAKE BOULEVARD BUFFALO, MN 55313		_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 318	receive AROM to L a day. RN Restorative Nu 10/21/14, indicated ROM/voluntary mo referral. The summ continue to dress u stand for transfers completed 27 out of good, goal appropri- higher level continu- with no decline. The Point of Care H September 2014- A greater 18 out of 30 times. The history not receive AROM October 2014- ARO and refused once. why she did not reo days. November 1st thru received for 15 min of 19 opportunities why R5 did not reco greater the remainin During interview 11 stated she was the today for 13 reside NA's on her unit. N	age 49 0/21/11, indicated she was to IE and LE for 15 minutes once rsing Monthly Review dated she had no changes in her vement and did not need a OT nary of her goal was to pper half of body and use indicated she continues to ogram with meeting goal. Has of 30 days. Tolerates fair to iate unable to progress to the to maintain current mobility History indicated the following: AROM occurred 15 minutes or 0 opportunities, and refused 3 did not indicate why she did the remaining 12 times. DM 27 out of 31 opportunities The history did not indicate ceive ROM the remaining four November 19th 2014- AROM outes or more occurred 16 out The history did not indicate eive AROM for 15 minutes or ng four opportunities. /19/14, at 9:01 a.m. NA- D only one working on her unit nts and they should have two IA-D said this happens at least ecause of that the restorative	F 318			

If continuation sheet Page 50 of 61

CENTEI STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	FORM A OMB NO. (X3) DATE	12/29/2014 APPROVED 0938-0391 SURVEY PLETED
		245513	A. BUILDING	ETNI	ΛI	
NAME OF	PROVIDER OR SUPPLIER	240010		TREET ADDRESS, CITY, STATE, ZIP CODE	11/2	20/2014
	DGE CARE CENTER		3	10 LAKE BOULEVARD		
	DGE CARE CENTER	OF BUFFALO	В	BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 318	Continued From pa	age 50 can not get completed.	F 318			
	PT-A stated the clin charge of the resto DON oversaw the nursing staff are to participating, has a fall. They were not	/20/14, at 11:25 a.m. with nical coordinators were in prative program and thought the program also. PT-A stated the inform us if a resident is not decline or has an injury with a t informed the restorative being completed as				
	stated there have be just isn't enough st programs and there the floor and know DON stated the nu the restorative prog- facility specific poli	/20/14, at 12:05 p.m., the DON been some days where there aff to complete the restorative e are days she is working on s it just can not get done. The rsing staff had been trained in grams and they do not have a cy but they follow the RAI ent instrument) manual.				
	clinical coordinator stated the nursing there restorative nu	/20/14, at 1:50 p.m. with registered nurse (RN)-D who assistance are to complete ursing and that she was not a unable to complete there				
	for the nurses and Restorative Nursin materials indicated restorative nursing by the nurse and for able to do the prog program found in y	d training 4/01/14 and 4/2/14 nursing assistance, on g Programs. The training "Each resident who is on a program has been assessed ound to be appropriate and rams listed on the restorative rour care books behind the et. Any information about the				

If continuation sheet Page 51 of 61

		HAND HUMAN SERVICES E & MEDICAID SERVICES			FORM	12/29/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245513	B. WING		11/2	20/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE <b>10 LAKE BOULEVARD</b>		
LAKE RI	DGE CARE CENTER	OF BUFFALO		BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 318 F 353 SS=E	to do them can be Coordinator can ar have about the pro- the resident is una program. Once yo program for your re- bottom of the sheet the restorative nur- to be in compliance you do have an ob 483.30(a) SUFFIC PER CARE PLANS The facility must he provide nursing an maintain the highe and psychosocial of determined by resi individual plans of The facility must p numbers of each of personnel on a 24- care to all resident care plans: Except when waive section, licensed n personnel. Except when waive section, the facility nurse to serve as a duty.	what programs and how often found there and the Clinical nswer any questions you may ogram or address it if you find ble or unwilling to follow the ou have been educated on the esident, please sign/date at the esident plan of care - so ligation here!". IENT 24-HR NURSING STAFF S ave sufficient nursing staff to d related services to attain or st practicable physical, mental, well-being of each resident, as dent assessments and	F 318			12/22/14
	This REQUIREME	NT is not met as evidenced				

If continuation sheet Page 52 of 61

		AND HUMAN SERVICES		FORM	): 12/29/2014 MAPPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245513	B. WING		/20/2014
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD	
LAKE RI	DGE CARE CENTER	OF BUFFALO		SUFFALO, MN 55313	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353		age 52	F 353		
	review, the facility f sufficient numbers to 8 of 15 residents R91, R121 and R22 In addition, for 2 of and FM-A) and 6 o medication assistan nurse (LPN)-B, nur registered nurse (R expressed concern	tion, interview and document ailed to allocated staff in to ensure care was provided (R66, R73, R42, R5, R18, 2) reviewed for personal cares. 2 family members (FM)-B, f 10 employees (trained nt) TMA-A, licensed practical sing assistant (NA)-D, NA-B, 2N)-C and NA-C, who had, and is about resident cares not r completed timely due to		<ul> <li>F353-E</li> <li>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.</li> <li>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.</li> </ul>	
	implement restorat improve and/or ma ambulation ability for and R42 ) in the sa Refer to F311 for fu The facility failed to services as ordered R66,R42, and R5) services to maintai (ROM). Refer to F The facility failed to for toileting for 1 of	o provide and consistently ive ambulation services to intain the resident's or 3 of 4 residents (R66, R73 ample reviewed for ambulation.		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 mos 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	t

Facility ID: 00714

CENTER		TH AND HUMAN SERVICES RE & MEDICAID SERVICES				APPROVE 0938-039
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245513	B. WING		11/	20/2014
NAME OF F	PROVIDER OR SUPPLIE	R	:	STREET ADDRESS, CITY, STATE, ZIP C	ODE	
LAKE RI	DGE CARE CENTE	R OF BUFFALO		310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 353	Continued From	page 53	F 353	3		
	The facility failed of 3 residents (R dependent upon	to provide routine bathing for 2 121 and R22) who were staff for activities of daily living. further information.		continue interview, select ar prospective nursing employed are available to provide the by our residents.	ees as they	
	cared-planned in nursing, oral care fall/accident prev (R66,R73,R42,R	to consistently implement terventions for restorative e, incontinence care and ention for 7 of 33 residents 5,R18,R121,R22) in the sample e plan implementation. Refer to al information.		3.Measures put in place to e deficient practice does not r Nursing schedules are poste two-week time periods, and positions are posted next to These vacant hours are ava current employees, and are to at least one pool agency be filled before the pay perior	ecur: ed for any vacant the schedule. iilable to also called in if they cannot od begins.	
	R22's quarterly N intact cognition, a assistance for tra	ADS, dated 10/28/2014, indicated and that she required extensive ansferring, bed mobility and most ed "Right now, there is really not		Bonuses have been and will be offered to fill vacant shift Advertisements for nurses a assistants have been and w be placed in local papers ur positions are filled. Location nursing assistant programs contacted to let them know	s. and nursing ill continue to itil any open ns that provide have been	
	enough staff ava can take up to ar assist, and "that's	ilable to help." R22 also said it hour to wait for someone to s no kidding."		positions. Any potential app contacted at our earliest cor arrange interviews, and sele employees will be done with	olicants will be nvenience to ection of new in the	
	indicated she rec mobility and trans intact cognition. wonderful job" ar	n MDS, dated 8/29/2014, juired staff assistance with bed sferring, and also that R124 had R124 stated "the staff do a nd added that the facility is just R124 said the staff "just can't		requirements of employmer allow for the proper care of we have also added on a pa nursing assistant to specific aide.	our residents, art-time	
	keep up."			4.Effective implementation of be monitored by:		
	intact cognition, a extensive assista dressing, and to	ADS, dated 11/4/2014, indicated and further that he required ance with bed mobility, transfers, ileting. R55 said that "staff have ney are short staffed." R55 also		Open positions and vacant s recorded on the schedule at explanation of how those op or vacant shifts were covered written in the Shift Coverage	nd an pen positions ed will be	

Facility ID: 00714

If continuation sheet Page 54 of 61

STATEMEN	T OF DEFICIENCIES DF CORRECTION	RE & MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION (X3) DA	D. 0938-039 TE SURVEY MPLETED
NAME OF	PROVIDER OR SUPPLII	<b>245513</b> ER	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	/20/201 <u>4</u>
LAKE R	DGE CARE CENTE	R OF BUFFALO	-	10 LAKE BOULEVARD UFFALO, MN 55313	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 353	said he has som longer just to ans "hollering out for stated if he yells, rest of the reside told me "to use m "they don't answit told me 'I have o R31's quarterly M intact cognition, a assistance with r dependent upon that it's not the s had to wait for ar bathroom, or bee bowel and bladd R64's quarterly M intact cognition, a assistance for be and toileting. In do not have enou frustrating when and toileting. In do not have enou frustrating when and then they lea back." R128's MDS, da had intact cognit she required stat toileting, persona mobility. R128 s and she often ha the morning. R1 and I wait. I thin During an intervi family member (	etimes waited 30 minutes or swer the call light, often times them to come and help." R55 he's afraid he may "wake up the ents." R55 added, that staff have ny call light," and then I tell staff er my light." R55 said "staff have ther people to take care of, too."" <i>I</i> IDS, dated 9/3/2014, indicated and that she required extensive nost ADLs, and was totally staff for bathing. R31 stated, taff's fault, but sometimes" I have n hour when I need to go to the d." R31 said she has had both	F 353	<ul> <li>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.</li> <li>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.</li> <li>Completion date for certification purposes only is: December 22, 2014</li> </ul>	f d

If continuation sheet Page 55 of 61

		AND HUMAN SERVICES			FORM	12/29/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245513	B. WING		11/:	20/2014
NAME OF I	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE RI	DGE CARE CENTER	OF BUFFALO	-	10 LAKE BOULEVARD		
			B	SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 353	Continued From pa	age 55	F 353			
		B said his mother could not	1 000			
	wait long enough for	or staff to assist her, before				
		FM-B said "I do not expect one for all the patients, but FM-B				
	emphasized the nu	mber of staff available to				
		her's needs, and other enough." FM-B stated he				
		often wait for help and that he				
	was concerned, "es help her."	specially when I am not here to				
	family member (FN wait for toileting he more than 10 minu hold it that long, an FM-A said "It's not more persons." FN helped" [R138] on	v on 11/18/2014 at 4:29 p.m., /)-A stated [R138] has had to lp "many times," and often ites. FM-A said "[R138] cannot id he has been incontinent." the girls' fault, they just need //-A said her son has "often the toilet, "and 10 minutes he call light on, a nurse shows				
	Complaints expres	sed by staff:				
	medical assistant ( and I also get pulle short staffed, we have	1/18/2014, at 7:35 p.m. trained TMA)-A stated "I pass meds to the floor when they are ave had staffing issues lately ir staff have left, and I don't				
	licensed practical r here is awful we h	/19/2014, at 7:44 a.m. hurse (LPN)-B stated "staffing ave no on-call nurses to fill in the nursing assistance are				

If continuation sheet Page 56 of 61

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			PRINTED: 12/29/2014 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245513	B. WING		11/20/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD	
LAKE RI	DGE CARE CENTER	OF BUFFALO		BUFFALO, MN 55313	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 353	my charting done, the time and we can During interview 1 assistant (NAR)-D working on her unit 12:00 p.m. we will building this seems week. I cant get m you look at the logs just so short staffed done and there are	age 56 residents up, I struggle to get call lights are going off all of int answer them timely." 1/19/2014, at 9:01 a.m. nursing stated she is the only the one t. I have 13 residents and after be down two aides in the s to happen at least once a by walks and charting done if s you can see that. We are d baths are not always getting e many blanks on the bath get my restorative rehab	F 353		
	interview with NAF day shift and feels are short staffed ar staffed every day a restorative nursing interview on 11/20/ stated the restorati be run 7 days a we her walks done, bu (ROM) programs d During interview 1 the administrator w challenging right no we have ads in the staff on a family me having the manage stay late to help. T	a 11/19/2014, at 12:04 p.m. R-B who stated I work full time the staffing here is terrible, we ad It seems like we are short and at times we cant get our completed. In a subsequent 2014 at 9:24 a.m., NAR-B ve nursing programs were to sek, and that she "usually" got t that "the range of motion			

If continuation sheet Page 57 of 61

	EALTH AND HUMAN SERVICES			PRINTED: 12/2 FORM APPR OMB NO: 0938	OVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURV COMPLETE	
DM	245513	B. WING		11/20/20	14
NAME OF PROVIDER OR SU	PPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RIDGE CARE CE	NTER OF BUFFALO		310 LAKE BOULEVARD BUFFALO, MN 55313		
PREFIX (EACH DEF	ARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE COMP	X5) PLETION ATE
it is not digita how long call not conduct of light system to answer the li do not have a During intervenurse (RN)-E clinical coord the floor toda staff on the fl the floor once aware the resi getting done her. During intervent stated she is today and that concern of ne told me "it ne there was en the residents times and sh residents at of bigger green that "there are lights." NA-C who start out job is not the and keep goo F 356 483.30(e) PC SS=C INFORMATIC	as an older call light system and that al so they can't run reports to see lights are left on for and that they do random audits with the current call to see how long it is taking staff to ghts. The administrator stated they a policy on staffing for the building. iew 11/20/14, at 2:18 p.m. registered b stated she is not working as a linator and she had been pulled to by because they do not have enough oor. The RN-D stated she works on e every two weeks and was not storative nursing programs were not and the staff should have informed iew 11/20/14, at 3:57 p.m. NA-C the only one working on her unit at she had informed the DON of her be having enough staff and the DON eeds to be done". She then stated if ough staff she would be able to toilet appropriately within the needed e further stated they don't check the hight for being wet they just put the pads on them at night. NA-C added re nurses who will not answer call c also said there were "many people that just don't work out and that "the right fit for them." "It's hard to find ob people for this job." OSTED NURSE STAFFING ON	F 353		12/1	5/14

If continuation sheet Page 58 of 61

		I AND HUMAN SERVICES E & MEDICAID SERVICES		FO	ED: 12/29/2014 RM APPROVED NO. 0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		DATE SURVEY COMPLETED
		245513	B. WING		11/20/2014
NAME OF I	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·
LAKE RI	DGE CARE CENTER	OF BUFFALO		10 LAKE BOULEVARD	
	SUMMARY ST	ATEMENT OF DEFICIENCIES		BUFFALO, MN 55313 PROVIDER'S PLAN OF CORRECTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From pa o Facility name.	age 58	F 356		
	o The current date.				
	by the following cat	and the actual hours worked tegories of licensed and staff directly responsible for bift			
	<ul> <li>Registered nu</li> <li>Licensed prace</li> </ul>				
	- Certified nurs o Resident census	e aides.			
	specified above on of each shift. Data o Clear and readat	ace readily accessible to			
	make nurse staffing	pon oral or written request, g data available to the public not to exceed the community			
	staffing data for a r	aintain the posted daily nurse ninimum of 18 months, or as aw, whichever is greater.			
	by:	NT is not met as evidenced tion, interview, and document		F356-C	
	review, the facility f hours worked for a posting. This had t	ailed to display the actual Il nursing staff on the daily staff the potential to affect all 54 d any visitors who may wish to		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 the	
	Findings include:			one was cited correctly. The Plan of Correction is submitted to meet	

Facility ID: 00714

If continuation sheet Page 59 of 61

TATEMENT	OF DEFICIENCIES F CORRECTION	RE & MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION (X3) DAT	<u>. 0938-039'</u> E SURVEY IPLETED
LAKE RI	PROVIDER OR SUPPLIE		3 <sup>,</sup> B	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD SUFFALO, MN 55313 PROVIDER'S PLAN OF CORRECTION	20/201 <u>4</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	During the initial at 9:10 a.m. a La Department form area of the buildi disciplines of reg practical nurses (TMA), and nursi along with each of The posting did ii (night shift) with a times for each shi identify the actual disciplines. During interview director of nursin hour shifts from 6 p.m. to 6:00 a.m. p.m.'s from 6:00 she was not awa listed on the staff During interview the administrator been changed in does not automa of the form. The was not sure if th hours in the past	tour of the facility, on 11/17/14, ke Ridge Care Center - Nursing was displayed in the commons ng. The posting indicated istered nurses (RN), licensed (LPN), trained medication aides ng assistant, registered (NA/R), disciplines total hours worked. ncluded Day shift and NOC no designated start and end hift. The posting also did not I hours worked by these on 11/18/14, at 7:41 p.m. with g (DON) stated the staff work 12 5:00 a.m. to 6:00 p.m. and 6:00 and they have a short shift on p.m. to 10 p.m. The DON stated re the actual hours needed to be	F 356	<ul> <li>requirements established by State and Federal law.</li> <li>It is the policy of Lake Ridge Care Center that nursing hours will be posted on a daily basis.</li> <li>To assure continued compliance, the following plan has been put into place;</li> <li>1. Regarding cited residents: <ul> <li>There were no residents cited regarding in this deficiency.</li> </ul> </li> <li>2. Actions taken to identify other potential residents having similar occurrences: <ul> <li>There are no other residents having similar occurrences as none can be identified.</li> </ul> </li> <li>3. Measures put in place to ensure deficient practice does not recur: <ul> <li>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.</li> </ul> </li> <li>4. Effective implementation of actions will be monitored by: <ul> <li>The charge nurse will use a checklist to track the posting of nursing hours daily.</li> <li>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.</li> <li>5. Those responsible to maintain</li> </ul></li></ul>	

Event ID: GGOI11

Facility ID: 00714

If continuation sheet Page 60 of 61

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY PLETED	
		245513	B. WING	ETN	11/20/2014		
NAME OF I	PROVIDER OR SUPPLIE	ĒR	S.	TREET ADDRESS, CITY, STATE, ZII			
LAKE RI	DGE CARE CENTE	R OF BUFFALO		10 LAKE BOULEVARD UFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 356	Continued From page 60		F 356	The Director of Nursing o maintain compliance with nursing hours.	the posting of		
				Completion date for certif only is: December 15, 2			

Facility ID: 00714

If continuation sheet Page 61 of 61

		AND HUMAN SERVICES & MEDICAID SERVICES	F	5513023	FORM OMB NO.	: 12/24/2014 APPROVED .0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION		E SURVEY IPLETED
		245513	B. WING		11/	18/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO		310 LAKE BOULEVARD BUFFALO, MN 55313		
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	NION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE OPRIATE	COMPLETION DATE
K 000	INITIAL COMMEN	rs ·	кo	000		
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE.				
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departm Fire Marshal Division At the time of this is Ridge Care Center compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National (NFPA) Standard 1	Survey was conducted by the nent of Public Safety, State on, on November, 18, 2014. survey, Building 01 of Lake was found not to be in e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01 Life Safety Code (LSC), g Health Care Occupancies.			1	
-	PLEASE RETURN CORRECTION FC DEFICIENCIES (K Health Care Fire In State Fire Marshal 445 Minnesota St., St. Paul, MN 5510 Facsimile: 651-21	R THE FIRE SAFETY -TAGS) TO: nspections Division Suite 145 1-5145		Ercc		
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
	nically 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.

		AND HUMAN SERVICES				FORM	12/24/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>			(X3) DATE SURVEY COMPLETED		
245513			B. WING	_		11/18/2014	
	PROVIDER OR SUPPLIER	OF BUFFALO		31	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa	ige 1	ĸ	000			
	By e-mail to: Marian.Whitney@s	tate.mn.us					
		RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION:					
	1. A description of to correct the defici	what has been, or will be, done ency.					
	2. The actual, or pr	oposed, completion date.					
	responsible for corr	r title of the person rection and monitoring to ence of the deficiency.					-
	no basement. The different times. The constructed in 1960 Type II(111) constru- was constructed ar Type II(111) constru- building and the 1 a type allowed for ex- surveyed as one build constructed in 2014	center is a 2-story building with building was constructed at 2 e original building was 0 and was determined to be of uction. In 1976, an addition nd was determined to be of uction. Because the original addition meet the construction isting buildings, the facility was uilding. The 3rd Addition was 4, is one-story, is fully fire and is of Type II(111)					

time of the survey.

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

construction.

Facility ID: 00714

If continuation sheet Page 2 of 6

		& MEDICAID SERVICES			OMB NO.	E SURVEY
TATEMENT ND PLAN O			A, BUILDIN	PLE CONSTRUCTION IG <b>01</b>		PLETED
245513			B. WING		11/	18/2014
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RII	DGE CARE CENTER	OF BUFFALO		310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
K 000	Continued From pa	ge 2	K 00	00		
K 018 SS=E	NOT MET as evide NFPA 101 LIFE SA	FETY CODE STANDARD	K 0'	18		12/15/14
	required enclosures hazardous areas and those constructed of wood, or capable of minutes. Doors in required to resist the no impediment to the are provided with a the door closed. D are permitted.	prridor openings in other than s of vertical openings, exits, or re substantial doors, such as of 1 <sup>3</sup> / <sub>4</sub> inch solid-bonded core f resisting fire for at least 20 sprinklered buildings are only ne passage of smoke. There is he closing of the doors. Doors means suitable for keeping utch doors meeting 19.3.6.3.6 9.3.6.3 prohibited by CMS regulations cilities.				
	NFPA 101 (2000) STANDARD - Dool in other than requir openings, exits, or substantial doors, s 1 <sup>3</sup> ⁄ <sub>4</sub> inch solid-bond resisting fire for at sprinklered building	is not met as evidenced by: LIFE SAFETY CODE SURVEY rs protecting corridor openings red enclosures of vertical hazardous areas are such as those constructed of led core wood, or capable of least 20 minutes. Doors in gs are only required to resist oke. There is no impediment		K018-E It is the intention of Lake Ridge ( Center to insure that all doors ar impeded from closing. The door to resident room #111 adjusted to correctly close and is longer impeded from closing and into its frame.	e not was s no	

Event ID: GGOI21

Facility ID: 00714

If continuation sheet Page 3 of 6

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			11/18/2014	
	PROVIDER OR SUPPLIER	OF BUFFALO		31	REET ADDRESS, CITY, STATE, ZIP CODE 0 LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	cc	(X5) DMPLETION DATE
K 018 K 062 SS=D	<ul> <li>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.</li> <li>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.</li> <li>FINDINGS INCLUDE:</li> <li>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.</li> <li>This deficient practice was verified by the Enviromental Services Director.</li> <li>NFPA 101 LIFE SAFETY CODE STANDARD</li> </ul>		K 018     The Environmental Director will to insure doors are not impeded closing.       Completion date for certification only is: December 15, 2014.		Completion date for certification purpos	lly es	2/19/14
	Based on observa facility failed to mai in accordance with NFPA 101, Section 1998 NFPA 25, sec	s not met as evidenced by: tion and staff interview, the ntain the fire sprinkler system the requirements of 2000 s 19.3.4.1 and 9.6, as well as tion 2-2.1.1 and 2-2.2. This ould affect all 57 out 57			K062-D It is the intention of Lake Ridge Care Center to maintain our automatic sprink system in reliable operating condition. The sprinkler heads in the kitchen and	ler	

Facility ID: 00714

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
245513       NAME OF PROVIDER OR SUPPLIER       LAKE RIDGE CARE CENTER OF BUFFALO			B. WING 11/18 STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIC DATE	
K 062 K 147 SS=E	<ul> <li>REGULATORY OR LSC IDENTIFYING INFORMATION)</li> <li>Continued From page 4 residents.</li> <li>Findings include:</li> <li>On facility tour between 8:45 am and 11:30 pm on 11/18/2014, observation revealed that the following were found:</li> <li>1. Kitchen- Dishwashing area, Walk in freezer and cololer, the fire sprinkler heads located in this area were corroded.</li> <li>This deficient practice was verified by the Enviromental Services Director.</li> <li>NFPA 101 LIFE SAFETY CODE STANDARD</li> </ul>		K 062	<ul> <li>dishwashing area were dusted and cleaned to insure that they remained in reliable operating condition. The sprin heads in the freezer and cooler were replaced as they showed signs of build and were beginning to corrode. We hadded the cleaning/dusting of sprinkle heads to our preventative maintenance program to be completed two times per year, or as necessary.</li> <li>The Environmental Director will monitor the sprinkler heads for continued reliation operation.</li> <li>Completion date for certification purpoonly is: December 19, 2014.</li> </ul>	kler d-up ave r e er or bility	
				K147-E It is the intention of Lake Ridge Care Center to provide electrical installation accordance with NFPA 70. The power strip that was used in the Therapy office was removed and the refrigerator is now plugged directly into outlet. The multi-plug adapters were removed in both the Therapy office an the Pine Room.	o an	

Facility ID: 00714

If continuation sheet Page 5 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES FO CENTERS FOR MEDICARE & MEDICAID SERVICES OMB I							
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mui A. Buile		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245513	B. WING	B. WING			8/2014
NAME OF I	PROVIDER OR SUPPLIER	0			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO			10 LAKE BOULEVARD UFFALO, MN 55313		
		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLÉTION DATE
K 147	7 Continued From page 5 office and Pine room.		K	147	to monitor for the proper use of ele installations.	ctrical	
	This deficient pract Enviromental Servi	ice was verified by the ces Director.			Completion date for certification pu only is: November 24, 2014.	rposes	
					т. Т		
			- 				
		8					
					8		

Event ID: GGOI21

Facility ID: 00714

If continuation sheet Page 6 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES			Ŧ	FORM APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG <b>02 - OASIS</b>	(X3) DATE SURVEY COMPLETED
		245513	B. WING		11/18/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				310 LAKE BOULEVARD	
	DOE OARE OERTER			BUFFALO, MN 55313	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
K 000	INITIAL COMMENT	S	K 00	o	
	FIRE SAFETY		17.		
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.			
	ONSITE REVISIT O CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE NS BEEN ATTAINED IN TH YOUR VERIFICATION.			
-	Minnesota Departm Marshal Division. A Ridge Care Center, was found in compl for participation in M Subpart 483.70(a), 2000 edition of Nati Association (NFPA)	Survey was conducted by the eent of Public Safety, Fire t the time of this survey,Lake Oasis wing (2014 addition) iance with the requirements Aedicare/Medicaid at 42 CFR, Life Safety from Fire, and the onal Fire Protection Standard 101, Life Safety ter 18 New Health Care.		EDOC	
	building built in 2014 Type 11 (111) const sprinkled protected fire alarm system w resident rooms, cor corridors that is mo department notification	enter Oasis Wing is a 1-story 4 and was determined to be of ruction. The building is fully throughout. The facility has a ith smoke detection in ridors and spaces open to the nitored for automatic fire tion. The facility has a s and had a census of 57 at		EPOC	
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE
	ically 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.

		AND HUMAN SERVICES				APPROVED
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	0938-0391 E SURVEY PLETED
	- CONRECTION		A, BUILDING 02 - OASIS			
		245513	B. WING		11	18/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO		310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
К 000	Continued From pa the time of the surv		K 00	00		
		-				e

Event ID: GGOI21

Facility ID: 00714

If continuation sheet Page 2 of 2