CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: GIFX

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

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY A	GENCY		Facility ID: 00550	
MEDICARE/MEDICAID PROVIDER N (L1) 245589 2.STATE VENDOR OR MEDICAID NO. (L2) 090243800	0.	3. NAME AND ADI (L3) BUFFALO L (L4) 703 WEST Y (L5) BUFFALO L	AKE HEALTH O	CARE CTR	368	55314	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation 7. On-Site Visit	N: 7 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF OWN (L9) 01/01/2009	NERSHIP	7. PROVIDER/SUF	PPLIER CATEGORY	Y 09 ESRD	02 (L7	7) 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 08/27 , 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(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 ENDIN	G DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	49 (L18) 49 (L17)	B. Not in Com	equirements	n	2. Tec 3. 24 4. 7-D	chnical Personnel	e Following Requirements:	ector	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	19 SNF	ICF	IID		15. FACILITY N 1861 (e) (1) or		(L15)		
(L37) (L38)	(L39)	(L42)	(L43)		()()	5 / (/			
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE SUI	RVEY AGENCY API	PROVAL	Date:	
Austin Fry, Hl	FE NE II		08/27/2015	(L19)	Kate Joh	nsTon, Pro	ogram Specialis	09/08/2015 (L20)	
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR	SINGLE STAT	TE AGENCY		
 DETERMINATION OF ELIGIBILITY X 1. Facility is Eligible to Part 2. Facility is not Eligible 			IPLIANCE WITH C HTS ACT:	CIVIL	2.		ial Solvency (HCFA-2572) Interest Disclosure Stmt (HC	FA-1513)	
2. Facility is not Engine	(L21)								
22. ORIGINAL DATE OF PARTICIPATION 11/01/1991	23. LTC AGREEMI BEGINNING		4. LTC AGREEME ENDING DATI		VOLUNTARY 01-Merger, Clos	ATION ACTION:	05-Fail to	(L30) NTARY Meet Health/Safety Meet Agreement	
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATIVI A. Suspension of		(L25) (L44)		03-Risk of Involution 04-Other Reason	untary Termination n for Withdrawal	OTHER 07-Provide 00-Active	er Status Change	
(L27)	B. Rescind Sus	pension Date:	(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS				
		00320							
	(L28)			(L31)	Posted 09	/29/2015 Co.			
31. RO RECEIPT OF CMS-1539	(L32)	. DETERMINATION (08/11/2015	OF APPROVAL DAT	ΓΕ (L33)	DETERMIN	ATION APPRO	VAL		



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered September 8, 2015

Mr. Mark Rust, Administrator Buffalo Lake Health Care Center 703 West Yellowstone Trail, P.O. Box 368 Buffalo Lake, Minnesota 55314

Re: Reinspection Results - Project Number S5589024

Dear Mr. Rust:

On August 27, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 27, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Licensing and Certification Program

Health Regulation Division kate.johnston@state.mn.us

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

Enclosure (s)

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered September 8, 2015

Mr. Mark Rust, Administrator Buffalo Lake Health Care Center 703 West Yellowstone Trail, P.O. Box 368 Buffalo Lake, Minnesota 55314

RE: Project Number S5589024

Dear Mr. Rust:

On July 24, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 9, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 27, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 8, 2015 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 July 9, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 18, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 9, 2015, effective August 18, 2015 and therefore remedies outlined in our letter to you dated July 24, 2015, 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 Regulation Division kate.johnston@state.mn.us

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

Enclosure (s)

cc: Licensing and Certification File

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245589	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/27/2015
Name	of Facility		Street Address, City, State, Zip Code	
BUFFALO LAKE HEALTH CARE CTR		703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314		

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	()	75) Date	(Y4)	Item	(Y5)	Date	(Y4)	Item	(Y	(5) [Date
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix	F0176	08/18/2015	1	ID Prefix	F0242	08/18/2015		ID Prefix	F0279		08/18/2015
Rea #	483.10(n)			Rea #	483.15(b)	_		Rea #	483.20(d), 483.20	(k)(1)	_
•	400.10(11)			LSC	400.10(5)			•	400.20(0), 400.20	/(К/(Т/	_
		_	-								
		0				0					0
		Correction				Correction					Correction
ID Prefix	F0309	Completed 08/18/2015	١.	ID Prefix	E0222	Completed 08/18/2015		ID Prefix	E042E		Completed 08/18/2015
	-	00/10/2013	'								00/10/2013
-	483.25			-	483.25(m)(1)				483.60(a),(b)		_
LSC		_		LSC				LSC			_
		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		•	1	ID Prefix		oop.otou		ID Prefix			oop.otou
Reg. #				Reg. #		-		Reg. #			_
LSC				LSC		=					_
						•	-				_
		Correction				Correction					Correction
ID Prefix		Completed	l ,	ID Prefix		Completed		ID Prefix			Completed
Reg. #	-			Reg. #		-		Reg. #			_
		_		LSC				LSC			_
Reviewed By	/ Reviewe	d By	Date	e:	Signature of Surve	yor:				Date:	
State Agenc	, В	F/KJ	09	/08/20	015	3392	5			08/27	/2015
Reviewed By		d By	Date	٠.	Signature of Surve	vor				Date:	
CMS RO	, — INGVIEWE	Jy	Jale		Orginature or ourve	,,				Duto.	
Followup to	Followup to Survey Completed on:								a Summary of		
	7/9/2015				Uncorrecte	a Deficiencies	CMS	-2567) Sent	to the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245589	(Y2) Multiple Construction A. Building B. Wing 01 - MAII	N BUILDING 01	(Y3) Date of Revisit 9/8/2015
Name of Facility		Street Address, City, State, Zip Code	
BUFFALO LAKE HEALTH CARE CTR		703 WEST YELLOWSTONE TRAIL	, PO 368

BUFFALO LAKE, MN 55314

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	C	Y5) Date	(Y4) Ite	em	(Y5)	Date	(Y4)	Item	((Y5)	Date
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix		08/18/2015	ID	Prefix _		08/18/2015		ID Prefix			_
Reg. #	NFPA 101		F	Reg. # NF	FPA 101	_		Reg. #			_
LSC	K0018			LSC K	0147			LSC			_
		Correction				Correction					Correction
ID Drofiv		Completed	ID.	Drofiv		Completed		ID Drofiv			Completed
ID Prefix						=					_
Reg. #			F	Reg. #		-		Reg. #			_
LSC		_		LSC _		-		LSC			
		0				0					0
		Correction				Correction					Correction
ID Prefix		Completed	ID	Prefix		Completed		ID Prefix	-		Completed
Reg. #				Reg. #		_		Reg. #			
LSC			'								_
		<u> </u>				-	+-				
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix			ID	Prefix _		-		ID Prefix			_
Reg. #			F	Reg. #				Reg. #			
LSC		_		LSC		-		LSC			- -
		Correction				Correction					Correction
ID Drofiv		Completed	ID.	Drofiv		Completed		ID Drofiv			Completed
						-					_
Reg. #			F	Reg. #		_		Reg. #			_
LSC		<u> </u>		LSC _		-		LSC			_
Reviewed By	Reviewe	ed By	Date:		Signature of Surve	eyor:				Date:	
State Agency	,	GS/KJ	09/0	8/2015	5	34764	4			09/0	8/2015
Reviewed By	Reviewe	ed By	Date:		Signature of Surve	eyor:				Date:	
CMS RO											
Followup to	Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of				1				
	7/8/2015			_	-				to the Facility?	YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered September 8, 2015

Mr. Mark Rust, Administrator Buffalo Lake Health Care Center 703 West Yellowstone Trail, P.O. Box 368 Buffalo Lake, Minnesota 55314

Re: Reinspection Results - Project Number S5589024

Dear Mr. Rust:

On August 27, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 27, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Licensing and Certification Program

Health Regulation Division kate.johnston@state.mn.us

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

Enclosure (s)

cc: Licensing and Certification File

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00550	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/27/2015
Name	of Facility		Street Address, City, State, Zip Code	
BUFFALO LAKE HEALTH CARE CTR		703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314		

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

Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Desfer		Correction Completed	ID Desfer		Correction Completed	ID Dest		Correction Completed
ID Prefix	-	08/18/2015	ID Prefix		08/18/2015		× 21545	08/18/2015
-	MN Rule 4658.0405 Subp.			MN Rule 4658.0520 Subp.			# MN Rule 4658.1320 A.B.C	;
		Correction			Carraction			Correction
		Correction Completed			Correction Completed			Correction Completed
ID Prefix	21565	08/18/2015	ID Prefix	21830	08/18/2015	ID Pref	x	
•	MN Rule 4658.1325 Subp.			MN St. Statute 144.651 Sul		Reg. LS	# 	
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix			ID Prefix			ID Pref		_
Reg. # LSC			Reg. # LSC			Reg.		_ _
		Correction			Correction			Correction
ID Danfin		Completed	ID Desfix		Completed	ID Deef		Completed
ID Prefix		-				ID Prefi		_
Reg. # LSC			Reg. # LSC			Reg. LS	# 	_
		Correction			Correction			Correction
ID Danfin		Completed	ID Desfix		Completed	ID Doof		Completed
ID Prefix		-				ID Pref		_
Reg. # LSC			Reg. # LSC			Reg.		
Reviewed By	RE	ву /KJ	Date: 09/08/20	Signature of Surve	•	025	Date:	/27/2015
State Agency	<u>'</u>					925		/27/2015
Reviewed By CMS RO	Reviewed I	Зу	Date:	Signature of Surve	yor:		Date:	
Followup to	Survey Completed on: 7/9/2015					Deficiencies. Was (CMS-2567) Ser	s a Summary of to the Facility?	NO
TATE FORM	1: REVISIT REPORT (5	/99)	'	Page 1 of 1			Event ID: GIFX12	

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: GIFX

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

	PART I - TO BE COM	IPLETED BY TI	HE STAT	E SURVEY AGENCY	Fac	eility ID: 00550	
MEDICARE/MEDICAID PROVIDER NO. (L1) 245589 2.STATE VENDOR OR MEDICAID NO. (L2) 090243800	(L3) BUFFALO I	DDRESS OF FACILIT LAKE HEALTH C (ELLOWSTONE T LAKE, MN	ARE CTR		4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 01/01/2009	01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Com	9. Other plaint	
6. DATE OF SURVEY 07/09/2015 8. ACCREDITATION STATUS: (0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) 02 SNF/NF/Dual L10) 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 D	ATE: (L35)	
	A. In Complian Program R. Compliance (L18) X B. Not in Com	TIS CERTIFIED AS: nce With equirements e Based On: Acceptable POC hpliance with Program ents and/or Applied W		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B*	6. Scope of Service 7. Medical Director		
14. LTC CERTIFIED BED BREAKDOWN	I			15. FACILITY MEETS			
18 SNF 18/19 SNF 49	19 SNF ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39) (L42)	(L43)					
16. STATE SURVEY AGENCY REMARKS (IF APPLI	CABLE SHOW LTC CANCELI	LATION DATE):					
17. SURVEYOR SIGNATURE		18. STATE SURVEY AGENCY APP	PROVAL	Date:			
Amy Charais, HFE N	IE II	08/04/2015	(L19)	Kate JohnsTon, Pro	ogram Specialist	08/07/2015 (L20)	
PART	II - TO BE COMPLETE	ED BY HCFA RE	GIONAL	OFFICE OR SINGLE STAT	E AGENCY		
DETERMINATION OF ELIGIBILITY		MPLIANCE WITH CI HTS ACT:	VIL	1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above :			
22. ORIGINAL DATE 23. LTC A	AGREEMENT	24. LTC AGREEME	NT	26. TERMINATION ACTION:	(L3	50)	
OF PARTICIPATION BEG 11/01/1991	SINNING DATE	ENDING DATE	:	VOLUNTARY 00 01-Merger, Closure	05-Fail to Mee		
(L24) (L41)	(L25)		02-Dissatisfaction W/ Reimbursemen	nt 06-Fail to Mee	t Agreement	
A. St	ERNATIVE SANCTIONS uspension of Admissions: escind Suspension Date:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider St 00-Active	atus Change	
D. Re	senia Suspension Date.	(L45)					
28. TERMINATION DATE:	29. INTERMEDIARY/O	CARRIER NO.		30. REMARKS			
	00320						
(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32. DETERMINATION	OF APPROVAL DAT	E	Posted 08/11/2015 Co			
(L32)			(L33)	DETERMINATION APPROV	VAL		



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered July 24, 2015

Mr. Mark Rust, Administrator Buffalo Lake Health Care Center 703 West Yellowstone Trail, P.O. Box 368 Buffalo Lake, Minnesota 55314

RE: Project Number S5589024

Dear Mr. Rust:

On July 9, 2015, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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:

Potential Consequences - 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 Health Regulation Division 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 August 18, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 18, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

Buffalo Lake Health Care Ctr July 24, 2015 Page 4

latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 9, 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 January 9, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an

Buffalo Lake Health Care Ctr July 24, 2015 Page 5

informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

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

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

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulation Division

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

Enclosure (s)

cc: Licensing and Certification File

PRINTED: 08/04/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245589	B. WING _		07/09/2015
NAME OF PR	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	
BUFFALO	LAKE HEALTH CARE C	TR		703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314	
(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 APPE DEFICIENCY)	OULD BE COMPLETION
F 000	INITIAL COMMENTS		F 00	00	
F 176 SS=D	as your allegation of of Department's acceptate enrolled in ePOC, you at the bottom of the fit form. Your electronic be used as verification. Upon receipt of an accon-site revisit of your validate that substant regulations has been your verification. 483.10(n) RESIDENT DRUGS IF DEEMED	ance. Because you are ur signature is not required rest page of the CMS-2567 submission of the POC will not compliance. ceptable electronic POC, an facility may be conducted to ial compliance with the attained in accordance with	F 1	76	8/18/15
	the interdisciplinary to §483.20(d)(2)(ii), has practice is safe. This REQUIREMENT by: Based on observation review, the facility fail assess, care plan, an allowing safe self adn 1 of 2 residents (R64) inhaled medication. Findings include: R64's History & (and) identified R64 had "definition of the same plants and the same plants are safe to safe the same plants are safe to safe the sa	determined that this is not met as evidenced n, interview, and document ed to comprehensively d obtain physician orders ninistration of nebulizers for		Preparation and execution of the response of the plan does not cor an admission or agreement by the provider of the truth of the facts al conclusions set forth in the staten deficiencies. The plan of correction prepared and/or executed solely the provisions of Federal and State require it. For the purposes of an allegation that the facility is not in substantial compliance with Feder equirements of participation, this	nstitute e e e e e e e e e e e e e e e e e e
	dated 7/8/15, identifie	· ·		response and plan of correction	
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

Electronically Signed 07/28/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		245589	B. WING _			7/09/2015	
NAME OF P	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CO	•	1700/2010	
				703 WEST YELLOWSTONE TRAIL, PO	O 368		
BUFFALO	LAKE HEALTH CARE	ECTR		BUFFALO LAKE, MN 55314			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 176	Continued From pa	age 1	F 1	76			
	"albuterol-ipratropic relieve shortness of obstructive pulmor NEBULIZATION so via a nebulizer everorders did not identify any medications." R64's initial care picture was a new admissiful dentify if R64 was medications or not a puring observation was lying in bed with nebulizer machine dresser, but the material medication is aerostresident) was lying side. No visible metersident was lying side. No visible metersident in the nebulizer. When interviewed registered nurse (Finebulizer on her not there currently was in the nebulizer for dispensed. She stayesterday, and had determine if she was own nebulizer treating forward R64 have as a self admissed because of the obsession was unaware how."	um [inhaled medication used to of breath from chronic hary disease] blutionInhale 3 ml [milliliters] have 6 hours." R64's physician tify she could self administer and dated 7/8/15, identified R64 ion. The care plan did not able to self administer her and 17/9/15, at 7:47 a.m. R64 th her eyes closed. R64 had a running on her bedside ask of the nebulizer (where solized and inhaled by the next to R64 in bed on her right edication was being dispensed		constitutes the facility is alle compliance in accordance with 7305 of the State Operation F176 Completion Date: Aug It is the intent of the Buffalo Healthcare Center to allow it self administer drugs if the interdisciplinary team feels the safe. Resident R64 has been associated has	vith section s Manual gust 18, 2015 Lake ndividuals to the practice is essed and it at she can her nebulizer. reviewed for n self made d the week of determine e plan and to allowing any Designee will this process focus on new Any problems ill be brought am for		
	mask and laid it on During interview or	n 7/9/15, at 8:03 a.m. the					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245589	B. WING		07/09/2015
	ROVIDER OR SUPPLIER	TR		STREET ADDRESS, CITY, STATE, ZIP CODE 703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 176	process for self admi includes an assessma a physicians order all administer medication assessment is compl administer their own DON stated R64 sho with a nebulizer withous having a physician or A facility Self Administrated 5/10/10, identificated 5/10/10, identifications to resident Self-Administrated 5/10/10, identificated 5/10/10, identifi	ON) stated the facility nistration of medications ent for safety, and obtaining owing them to self in. No formal "typed out" eted for residents who self nebulizers. Further, the uld not have been left alone out being assessed, and der obtained. Itering Medications policy, ited the facility "should itering Medications policy, ited the facility "should itering Medications policy, applicable Law and Manual [SOM] with respect instration of medications." aff to "assess and "Self-Administration of ind appropriate", and, or Self-Administration list the other resident may ERMINATION - RIGHT TO right to choose activities, in care consistent with his or ments, and plans of care; is of the community both a facility; and make choices or her life in the facility that	F 17		8/18/15
		and document review the e residents were given a		F242 Completion Date: August 18, 20 It is the intent of the Buffalo Lake	115

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245589	B. WING _			07/09/2015	
	ROVIDER OR SUPPLIER LAKE HEALTH CARE	CTR	•	STREET ADDRESS, CITY, STATE 703 WEST YELLOWSTONE TR BUFFALO LAKE, MN 5531	RAIL, PO 368		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE	
F 242	Findings include: R50's quarterly mini 5/11/15 indicated he impaired, and needed transfers, ambulation staff for bathing. R50's admission ME he was alert and orisimportant to choose bed bath or sponge R50's preference. R50's care plan date alteration in self care one staff for bathing preference. During and interview stated he receives a and had never been shower. During a co 07/09/15, at 9:20 a. received a shower she further stated, "I easier, but they don would be nice to have director of nursing (I bathing preferences admission, during th stated the facility off could ask for a show	eference for 1 of 3 residents to make this choice. mum data set (MDS) dated was moderately cognitively ed extensive assistance with an and required assist of one OS dated 8/15/14, identified entated, and it was very between a tub bath, shower, bath, but did not identify ed 06/11/15, indicated an eability and required assist of but did not indicate a bathing of on 7/7/15, at 3:26 p.m., R50 whirlpool bath each week given the choice to take a nsecutive interview on m., R50 stated he had not ince admission, just baths. would prefer a shower, its of thave a shower that works. It	F2	Healthcare Center for choose the type of bat they would like. Resident R50 was into bathing preference an updated with his choice. All residents will be intreported bathing preference and updated with his choice. All residents will be entreported bathing preference for staff to accompany to the company of the change their mind at a wish is to be followed. The Director of Nursing monitor for compliance through random audits x 4 and then quarterly conferences. Any component to the QA conferencement of the company of the company of the process of the company of the process.	thing preference erviewed for his and his Kardex ce. terviewed and their erence added to the cess for bathing. ducated on the need preference with the eresident can any time and their ewith the process s on a weekly basis with resident care incerns will be		

AND DLAN OF CORRECTION INDENTIFICATION NUMBER		` ′	ELE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245589	B. WING		07/09/2015
	ROVIDER OR SUPPLIER LAKE HEALTH CARE	CTR	•	STREET ADDRESS, CITY, STATE, ZIP CODE 703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314	·
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
	should have been list the facility has the a throughout the build During an interview registered nurse (RI director (AD) asks the preference and then a preference. If a rewould put it on the conthe kardex for the During an interview AD stated she was the R50's assessment for the same getting a bath in are okay with it." The was offered a showed During an interview NA-C stated, "Eventhe unit but resident shower. 483.20(d), 483.20(k) COMPREHENSIVE A facility must use the todevelop, review a comprehensive planton for each reside objectives and timet medical, nursing, and the same control of the same c	sted on R50's care plan, and bility to utilize showers ing. on 07/09/15, at 8:00 a.m., N)- B stated, the activity ne question regarding bathing will tell me if the resident has sident had a preference, she are plan and it would be listed e nursing assistants. on 7/9/15, at 9:36 a.m., the he person who filled out or preferences for customary she "will tell the resident they the whirlpool and ask if they ere was no indication R50 er instead of a bath. on 7/9/15, at 10:25 a.m. yone gets a whirlpool bath" on shave the option for a 0(1) DEVELOP CARE PLANS he results of the assessment and revise the resident's	F 24		8/18/15

AND PLAN OF CORRECTION INTEREST.		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		245589	B. WING _		0	7/09/2015
	ROVIDER OR SUPPLIER	TR		STREET ADDRESS, CITY, STATE, ZIP CODE 703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314	DE .	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	to be furnished to atthighest practicable ppsychosocial well-be §483.25; and any set be required under §4 due to the resident's §483.10, including the under §483.10(b)(4). This REQUIREMENT by: Based on interview, facility failed to devel plan to include acceemergency procedur who received hemode. R57's admission Min 3/24/15, identified R5 cognitively impaired, (ESRD), and receive facility. R57's care plan, date to dialysis three times of fistula (connection used to start dialysis care plan identified s	lescribe the services that are ain or maintain the resident's hysical, mental, and ing as required under roices that would otherwise 83.25 but are not provided exercise of rights under e right to refuse treatment T is not met as evidenced and document review, the op a comprehensive care as site, special care, and les for 1 of 1 residents (R57) ialysis at an outside facility. Immum Data Set (MDS) dated for was moderately had end stage renal disease d hemodialysis at an outside at 7/7/15, identified she went as a week, and had a history between an artery and vein ocomplications. Further, the everal interventions for R57	F 2	F 279 Completion Date: Augus It is the intent of the Buffalo Lak Healthcare Center to develop a comprehensive care plan for ea resident that includes measurab objectives and timetables to me resident¿s medical, nursing, me psychosocial needs that are ide the comprehensive assessment R 57¿s care plan has been updinclude information on how to ca R57 and an emergency plan if u make dialysis, monitoring and caccess site, and interventions to the elevated risk of bleeding. There are no other residents cut the facility receiving dialysis.	ch ole et a ental and ntified in ated to are for unable to are of the o reduce	
	restriction", "assist w to and from dialysis a "Ensure dialysis com completed, and read dialysis." However, t	cubic centimeters] fluid ith arranging transportation appts [appointments]", and, munication form is upon [R57] return from he care plan lacked any ice about how to care for		Facility staff have been educate requirements under F279 relate dialysis care. The Director of Nursing or Designeries the care plan for dialysis	d to gnee will	

PRINTED: 08/04/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245589	B. WING _			07/	09/2015
	ROVIDER OR SUPPLIER	TR		70	REET ADDRESS, CITY, STATE, ZIP CODE 3 WEST YELLOWSTONE TRAIL, PO 368 UFFALO LAKE, MN 55314		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279 F 309 SS=D	scheduled dialysis ap care of the access sit and or signs and symidentify interventions risk for bleeding. During an interview of director on nursing (Enot identify care of the in case of an emerge 483.25 PROVIDE CAN HIGHEST WELL BEIL Each resident must reprovide the necessary or maintain the higher mental, and psychosometric signs and signs are signs are signs and signs are signs a	plan if unable to make a pointment, monitoring and e (fistula) for complications ptoms of infection, and to reduce R57's elevated n 7/9/15, at 11:03 a.m. the DON) stated the facility did e access site, or what to do ncy for R57. RE/SERVICES FOR NG ecceive and the facility must y care and services to attain st practicable physical,		809	to be sure it is updated with the necess information. Any concerns or problems will be brought to the QA team for recommendations.		8/18/15
	by: Based on observation review, the facility fail therapy (OT) recomminglemented to reduce edema and skin breat (R2) who utilized an eto provide compression Findings include: R2's quarterly Minimus 5/8/15, identified R2 is	ce the risk of increased kdown for 1 of 1 residents edema glove, a device worn on.			F 309 Completion Date: August 18, 20 It is the intent of the Buffalo Lake Healthcare Center to be sure each resident in the facility receives the necessary care and services to attain of maintain the highest practicable physic mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. R2 has been referred by the physician OT to evaluate for appropriate restoration programming.	or al, for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245589	B. WING		07/09/2015	
	ROVIDER OR SUPPLIER	TR		STREET ADDRESS, CITY, STATE, ZIP CODE 703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
F 309	and received no "splirestorative programm" During observation of was seated in a high-commons area watch contractures in her let touching each other. Ther left hand, to help her fingers. When interviewed on registered nurse (RN contracture of her left devices, as they were time." During observation of was seated in a reclin watching TV. R2 did left hand. Review of R2's care R2 had brain damage identified as "contractive programmes"	with activities of daily living int or brace assistance" ning during the review period. In 7/8/15, at 10:24 a.m. R2 back wheelchair in the ning television. R2 had ift hand with her fingers. There were no devices on decrease pressure between 17/8/15, at 10:44 a.m. 1)-A stated R2 had a thand, but did not wear any is more recommended at this	F 309	,	ot to vere oe setting am to e will ocess ods.	
	splint, but none recor Further, the care plan which directed staff to program as developed Review of R2's OT T Discharge Summary identified, "The patien misalignment and De of L [left] hand mult to be inappropriate.	mmended at this time." In identified an intervention o complete, "Nursing rehabed by therapy/nursing." herapist Progress & (and) form dated 11/7/14,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245589	B. WING		07/09/2015	
	ROVIDER OR SUPPLIER LAKE HEALTH CARE	CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314	·	
(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 SHOUL CROSS-REFERENCED TO THE APPROPRIES OF THE	D BE COMPLETION	
F 309	During interview on assistant (NA)-A sta any devices R2 use When interviewed of stated R2's left han as I've been here." wash her hand twice any devices being to During interview on occupational therap started working at the dismissed from OT for several years, a in November 2014. with an established edema glove being protect her skin. No keep the glove on, completed with staff the glove and care	I to use edema glove for finger ssist in cleanliness of L hand." 7/8/15, at 6:47 p.m. nursing ated she was "not aware" of	F 30	, , , , , , , , , , , , , , , , , , ,		
	stated she was una for R2 to be using a obviously didn't get During interview on director of nursing (OT had questioned but was unaware of or nursing being ins Further, the DON s	on 7/9/15, at 8:57 a.m. RN-A ware of OT's recommendation in edema glove, adding, "We the recommendations." 7/9/15, at 9:06 a.m. the DON) stated she was aware using an edema glove for R2, frany referral being completed structed to use the glove. tated if OT had made it was expected "that its				

l' '		IDENTIFICATION NUMBER		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245589	B. WING _			07/09/2015	
	ROVIDER OR SUPPLIER	TR		STREET ADDRESS, CITY, STATE, ZIP 703 WEST YELLOWSTONE TRAIL, BUFFALO LAKE, MN 55314			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 332 SS=D	stated she had worke to OT-A starting at th determined to need a fingers apart" and pre "That's what we want they completed traini staff on the use of the programs be followed stated the edema glo R2. 483.25(m)(1) FREE OR RATES OF 5% OR M	7/9/15, at 11:05 a.m. OT-B and with R2 in the past, prior be facility. R2 was an edema glove to "keep the event skin breakdown, to prevent." OT-B stated and with some of the nursing be glove, and expected "our at through." Further, OT-B are should still be worn by OF MEDICATION ERROR HORE	F3			8/18/15	
	by: Based on observation review, the facility fail were administered and and manufacturer instresidents (R53, R38) medication during the facility medication error Findings include: R53's quarterly Mining 4/10/15, identified R50 During observation of the facility medication of the facility medication error for the facility medication error for the facility medication of the facility facility facility medication of the facility faci			F 332 Completion Date: It is the intent of the Buffa Healthcare Center to ensurerrors do not occur. The order for R53 was concentred the survey when it was identified the survey. All staff will be re-educated August 10, 2015 on proper administration to prevent errors.	alo Lake ure medication arrected during entified. The te proper for R38 during ed the week of ter medication		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		245589	B. WING			07/09/2015	
	ROVIDER OR SUPPLIER	CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314		1 01/103/2010	
(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) COMPLETION DATE	
F 332	(RN)-A prepared two levothyroxine (medical 112 mcg (microgram omeprazole (medical 20 mg (milligrams) of cart in the commons pills in a white medical them to R53 who was reviewed with RN-A identified an order of [everyday]" RN-A Administration Recce 6/12/15 and only diring of omeprazole to telephone call to R5 clarification. At 10:3 the facility, and stating of omeprazole enhald been given the "That is an error." "Review of R53's M R53 had received, "CAPSULE Give 2 day", despite the production of the directing staff to give R38's quarterly MDS had moderate cognition physician orders day for, "Spiriva Respiration used to shortness of breath; puff inhale orally on	o separate medications, cation for thyroid disorder) ins) one tablet and ation used to treat heartburn) one tablet for R53 at a mobile is area. RN-A placed the two cation cup, and administered as in bed. ers dated 7/2/15, were is on 7/9/15, at 10:22 a.m. and of, "Omeprazole 40 mg QD in A stated R53's Medication ord (MAR) was updated on rected staff to administer 20 on R53. RN-A placed a sid's physician seeking incorrect dose of omeprazole, incorrect dose of omeprazole, AR dated 7/2015, identified incorrect dose of omeprazole, AR dated 7/2015, identified incorrect dose of omeprazole, AR dated 7/2015, identified incorrect dose of omeprazole, S dated 4/3/15, identified R38 itive impairment. R38's ted 6/5/15, identified an order intat Aerosol Solution treat bronchospasm and 12.5 mcg/act [actuation] 2	F 33	The Director of Nursing or Design monitor for compliance with this through weekly observation/au Further observation/audits will completed by the pharmacy of a quarterly basis and reported committee for any recommend	is process udits x4. be onsultant on to the QA		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245589	B. WING			07/	09/2015
	ROVIDER OR SUPPLIER	TR		7	TREET ADDRESS, CITY, STATE, ZIP CODE 03 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 332	(TMA)-A removed the from a mobile cart in R38's room, primed to approximately 2 inch While holding the debutton to aerosolize to devices mouthpiece causing the medication. TMA-A instructed R3 the medication which then provided him with afterwards. When in following the inhaler she holds the provided that is the provided t	n. trained medication aide e Spiriva Respimat inhaler the hallway. TMA-A entered he device and held it es away from R38's mouth. vice, TMA-A pressed the he medication while the was away from R38's mouth, on to mist into the air. 8 to breath deeply to inhale is was already in the air. She th a drink of water terviewed immediately administration, TMA-A stated back away from the mouth esn't touch it." on was described to RN-A on who stated an inhaler up to their [resident] mouth" The resident (R38) "would proper dosage" if the device his (R38's) mouth. Further, and be considered a ckage insert titled, Using at Inhaler dated 2015, ing is completed by, and fully, and then close your of the mouthpiece" 1/9/15, at 11:47 a.m. the eON) stated medication ed according to physician er needs to be administered cturer guidelines or it is "not	F	332			

OL. VIEI	C. C. M.EBIOMILE G	MEDIO/ (ID CEITVICE)				1	7. 0000 0001
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245589	B. WING			07/	09/2015
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BUFFALO	LAKE HEALTH CARE C	TR			03 WEST YELLOWSTONE TRAIL, PO 368 UFFALO LAKE, MN 55314		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 332	A facility General Dos Medication Administra identified, "Facility sta medication name and	se Preparation and ation policy dated 1/1/13, aff should verify that the dose are correct" rected staff to, "Follow	F	332			
F 425 SS=D	•		F	425			8/18/15
	drugs and biologicals them under an agree §483.75(h) of this par unlicensed personnel law permits, but only supervision of a licen. A facility must provide	rt. The facility may permit I to administer drugs if State under the general used nurse. e pharmaceutical services that assure the accurate					
		rugs and biologicals) to meet					
	a licensed pharmacis	oloy or obtain the services of st who provides consultation provision of pharmacy /.					
	by: Based on observatio review, the facility fail	on, interview, and document led to ensure that medication or 2 of 10 residents (R57, labels observed.			F 425 Completion Date: August 18, 20 It is the intent of the Buffalo Lake Healthcare Center to provide routine at emergency drug and biologicals to its		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L LIDENTIFICATION NITIMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245589	B. WING _			07/	09/2015	
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				70	03 WEST YELLOWSTONE TRAIL, PO 368			
BUFFALO	LAKE HEALTH CARE (CTR		В	SUFFALO LAKE, MN 55314			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 425	Continued From pag	e 13	F4	425	residents and ensure that medication			
	Findings include:				labels are correct for residents.			
	identified an order fo [medication used for 20 mg [milligrams] time a day for Hearth During observation of on 7/8/15, at 5:25 p.r package of Omeprazadminister to R57, at for review. The med TAB BY MOUTH EV 30 MINUTES BEFOR R57's Medication Addirects staff to adminevening, and the timelabel (every morning) When interviewed or stated R57's Omeprasupper", and the medication error. PN-A state pharmacy with new on medication error. R57's admission Min 3/24/15, identified R8 cognitively impaired, (ESRD), and receive outside dialysis center R57's Physician's Or 6/2/15, identified and Prilocaine cream [medication erroam [medication erro	of medication administration m. TMA-A removed a cole from a mobile cart to and provided it to the surveyor ication label identified, "1 ERY MORNING - TAKE 15 - RE A MEAL." TMA-A stated ministration Record (MAR) ister the medication in the efor administration on the lowas inaccurate. 10. 7/8/15, at 5:29 p.m. LPN-A azole had been given "before dication was mis-labeled. It is a standard to standard the orders" adding it so "there is imum Data Set (MDS) dated for was moderately had end stage renal disease d hemodialysis from an er. 11. der Summary Report, dated order for, "Lidocaine and edication cream used to			For R57 the omeprazole directions change stickers have been applied to the medication to indicate that the MAR is a order staff are to follow and the pharmath has been updated with the correct directions to be applied to future medication. The Lidocaine and Prilocal cream has been changed to be administered at 5am, 1-2 hours prior to dialysis. All medication labels will be checked to make sure they reflect the current physicians order. All medication staff will be educated the week of August 10, 2015 on proper medication administration to prevent medication errors, including the process to follow if they come across a label that does not match the MAR. The Director of Nursing or Designee will monitor for compliance with this process through weekly observation/audits x4. Further observation will be completed by the pharmacy consultant on a quarterly basis and reported to the QA committee for any recommendations.	the acy ine s s at		
	reduce pain during n	eedle insertion for dialysis] 6 to fistula site prior to						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245589	B. WING		07/09/2015	
	ROVIDER OR SUPPLIER LAKE HEALTH CARE	CTR	7	STREET ADDRESS, CITY, STATE, ZIP CODE 103 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314	,	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
F 425	During observation 7/8/15, at 3:53 p.m. Prilocaine cream wa The medication labe instructions, " app 1 to 2 hours before dressing (saran wraidentified the order primary nephrologis When interviewed ostated she sometim dialysis needles we "Someday's it hurts been putting a medinight before dialysis facility. During interview on dialysis registered in Lidocaine cream sh prior to her dialysis the cream the night pointless." When interviewed opharmacy consultar medicated cream sh before dialysis "to be During telephone in MD-E (R57's nephrostaff should be followapplying the medicated cream shedicated cream shed	of medication storage on R57's tube of Lidocaine and as in a mobile medication cart. el identified the following ly small amount to access site dialysis. Cover with occlusive in p." Further, the label had been written by R57's it, medical doctor (MD)-E. on 7/8/15, at 8:01 p.m. R57 es would have pain when the re inserted adding, more than others." Staff had icated cream on her arm the is since she admitted to the 7/9/15, at 10:21 a.m. R57's ould be applied 1-2 hours treatment, and that applying before would "be totally on 7/10/15, at 10:47 a.m. the off (PC) stated R57's nould be applied "2-3 hours"	F 425			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION S	(X3) DATE SURVEY COMPLETED		
		245589	B. WING		07/09/2015	
	ROVIDER OR SUPPLIER	CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
F 425	an order for, "Sennarelieve constipation] Give 1 tablet by mound the properties of t	rs dated 6/30/15, identified as [medication used to 8.6-50 mg [milligrams] th one time a day" f medication administration m. trained medication aide bottle of Senna from a ster to R25, and provided it view. The medication label ABS BY MOUTH IN THE stated R25 had a new order all weeks prior, and the label alert staff. Further, TMA-A ld have had a sticker placed refer to the current mistakes aren't made." 17/8/15, at 6:00 p.m. rse (LPN)-A stated R25's anged on 6/29/15, and icker placed on the label to	F 42	25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245589	B. WING _			07/09/2015		
NAME OF PROVIDER OR SUPPLIER BUFFALO LAKE HEALTH CARE CTR				STREET ADDRESS, CITY, STATE, ZIP CODE 703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE			
F 425	Continued From page A facility medication is requested, but none of	e 16 abeling policy was	F 4:	DEFICIENCY)				

DEPARTMENT OF HEALTH AND HUMAN SERVICES F 5589623

PRINTED: 07/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		245589	B, WING			07/	08/2015
NAME OF PROVIDER OR SUPPLIER BUFFALO LAKE HEALTH CARE CTR				70	REET ADDRESS, CITY, STATE, ZIP CODE 13 WEST YELLOWSTONE TRAIL, PO 368 UFFALO LAKE, MN 56314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	K 0	00			
	FIRE SAFETY	Company of the state of the state of					
	Minnesota Departm Fire Marshal Division time of this survey, Healthcare Center of compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F (NFPA) 101 Life Sa Existing Health Car						
\$	was constructed as The original building one-story, has no b protected and is of The 1st Addition was one-story, has no b protected and is of The 2nd Addition was one-story, has no b protected and is of The 3rd Addition was one-story, has no b protected and is of the story, has no b protected and is of the story, has no b protected and is of the story, has no b protected and is of the story, has no b protected and is of the story, has no b protected and is of the story, has no b protected and is of the story, has no b protected and is of the story, has no b protected and is of the story, has no b protected and is of the story, has no b protected and is of the story.	g was constructed in 1960, it is asement, is fully fire sprinkler Type II(000) construction; is constructed in 1965, it is asement, is fully fire sprinkler Type II(000) construction; as constructed in 1982, it is asement, is fully fire sprinkler Type II(000) construction; as constructed in 1993, it is asement, is fully fire sprinkler Type II(000) construction.					
		rated from both Building 02, sisted living facility, by proper ssemblies.					
	detection in the corr corridors which is m department notificat	re alarm system with smoke ridors and spaces open to the nonitored for automatic fire tion. The facility has a and had a census of 47 at					

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

TITLE

(X6) DATE

Electronically Signed

07/28/2015

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

PRINTED: 07/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 01 - MAIN BUILDING 01 245589 B. WING 07/08/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 703 WEST YELLOWSTONE TRAIL, PO 368 **BUFFALO LAKE HEALTH CARE CTR BUFFALO LAKE, MN 55314** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) K 000 Continued From page 1 K 000 time of the survey. K 018 NFPA 101 LIFE SAFETY CODE STANDARD K 018 8/18/15 SS=F Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1% inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY K 018 Completion Date: August 18, 2015 STANDARD - Doors protecting corridor openings It is the intent of the Buffalo Lake in other than required enclosures of vertical Healthcare Center to maintain all corridor openings, exits, or hazardous areas are doors in the means of egress in substantial doors, such as those constructed of accordance with NFPA 101 (2000) 1% inch solid-bonded core wood, or capable of Chapter 19, Section 19.3.6.3. resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist The Administrator and Maintenance the passage of smoke. There is no impediment Supervisor will be responsible for to the closing of the doors. Doors are provided maintaining the corridors doors in the with a means suitable for keeping the door means of egress so that they positively closed. Dutch doors meeting 19.3.6.3.6 are latch into the frame. permitted. NFPA 101 (00), Chapter 19, Section

O E I T I E I	TO I OIT WILDION	A MEDIONID SERVICES		OWBING	7. 0930-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED	
		245589	B. WING		/08/2015	
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	70072010	
BUFFALO	O LAKE HEALTH CAI	RE CTR		03 WEST YELLOWSTONE TRAIL, PO 368 UFFALO LAKE, MN 55314		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 018	Based upon observed corridor door which closing and latching emergency, this de	s not met as evidenced by: vation, the facility had a was impeded from fully g into its frame. In a fire ficient practice could adversely dents, staff and visitors due to	K 018	A new latch has been ordered and will be installed on the corridor door to the clean linen room #7.		
	the corridor door to	2:30 PM, observation revealed the clean linen room #7 did into its frame because the				
K 147 SS=F	Maintenance Super (MR) NFPA 101 LIFE SA Electrical wiring and	ice was verified by the rvisor (RH) and Administrator FETY CODE STANDARD d equipment is in accordance	K 147		8/18/15	
	This STANDARD is Based on observationstallations are not "The National Elect section 9.1.2. This effect the 30 of 49 is Findings include:	veen 12:30 PM and 3:30 PM		K 147 Completion Date: August 18, 2015 It is the intent of the Buffalo Lake Healthcare Center maintain electrical wiring and equipment in accordance with NFPA 70, National Electrical Code 9.1.2. The Administrator and Maintenance Supervisor will be responsible for maintaining the electrical wiring and equipment.		
		tension cord plugged into a dministrator's office.		All extension cords will be removed from		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245589	B. WING.		07.	/08/2015	
	PROVIDER OR SUPPLIER O LAKE HEALTH CAR	RE CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 703 WEST YELLOWSTONE TRAIL, PO 36 BUFFALO LAKE, MN 55314			
(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 SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
K 147	power strip in the b 3. RM 204 had an a extension cord.	tension cord plugged into a	K 14	service. An electrician is installin additional electrical outlets in the room 204 and break room.		2.6	
	This deficient practi Maintenance Super Administrator (MR)	visor (RH) and the					
						*	

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NAME OF PROVIDER OR SUPPLIER BUFFALO LAKE HEALTH CARE CTR TOTAL SUMMARY STATEMENT OF DEFICIENCIES PROVIDED REACH SEPCIES OF MUST BE PRECEDED BY PLUL REQUIRED AND FOR STATEMENT OF DEFICIENCIES K 000 INITIAL COMMENTS BUILDING OF SUMMARY STATEMENT OF DEFICIENCIES FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on, July 08, 2015. At the time of this survey, Building 02 of Buffalo Lake Healthcare Center was found in substantial compliance with the requirements for participation in Medicare/Medical at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Building 02 of Buffalo Lake Healthcare Center consists of the 2012 and 2014 resident room additions. Building 02 is separated from Building 01 by proper two-hour fire wall assemblies. The facility has a fire alarm system with smoke detection in the corridors which is monitored for automatic fire department notification. The facility has a capacity of 49 beds and had a census of 47 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by: ABDRIALORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE TITLE POS DATE ABDRIALORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE TITLE POS DATE ABDRIALORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2012 BUILDING ADDITION			(X3) DATE SURVEY COMPLETED	
TO SWEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314			245589	B. WING		07/	08/2015
RECULATORY OR LSC IDENTIFYING INFORMATION) K 000 INITIAL COMMENTS K 000 INITIAL COMMENTS K 000 K 000			RE CTR		703 WEST YELLOWSTONE TRAIL, PO 368		
A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 08, 2015. At the time of this survey, Building 02 of Buffalo Lake Healthcare Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Building 02 of Buffalo Lake Healthcare Center consists of the 2012 and 2014 resident room additions. Building 02 is nee-story in height, has no basement, is fully sprinklered and was determined to be of Type V (111) construction. Building 02 is separated from Building 01 by proper two-hour fire wall assemblies. 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 49 beds and had a census of 47 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 08, 2015. At the time of this survey, Building 02 of Buffalo Lake Healthcare Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Building 02 of Buffalo Lake Healthcare Center consists of the 2012 and 2014 resident room additions. Building 02 is one-story in height, has no basement, is fully sprinklered and was determined to be of Type V (111) construction. Building 02 is separated from Building 01 by proper two-hour fire wall assemblies. 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 49 beds and had a census of 47 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000	INITIAL COMMENT	rs ·	K 00	0		
Minnesota Department of Public Safety, State Fire Marshal Division, on July 08, 2015. At the time of this survey, Building 02 of Buffalo Lake Healthcare Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Building 02 of Buffalo Lake Healthcare Center consists of the 2012 and 2014 resident room additions. Building 02 is one-story in height, has no basement, is fully sprinklered and was determined to be of Type V (111) construction. Building 02 is separated from Building 01 by proper two-hour fire wall assemblies. 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 49 beds and had a census of 47 at time of the survey. The requirement at 42 CFR, Subpart 483,70(a) is MET as evidenced by:		FIRE SAFETY					
APORATORY DIRECTOR'S OR PROVIDER/SLIPBLIER REPRESENTATIVE'S SIGNATURE.		Minnesota Departm Fire Marshal Division time of this survey, Healthcare Center of compliance with the in Medicare/Medical 483.70(a), Life Safe edition of National F (NFPA) 101 Life San New Health Care Of Building 02 of Buffat consists of the 2012 additions. Building no basement, is full determined to be of Building 02 is separ proper two-hour fire The facility has a fir detection in the corr corridors which is medical capacity of 49 beds time of the survey.	nent of Public Safety, State on, on July 08, 2015. At the Building 02 of Buffalo Lake was found in substantial e requirements for participation id at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association fety Code (LSC), Chapter 18 occupancies. Illo Lake Healthcare Center 2 and 2014 resident room 02 is one-story in height, has by sprinklered and was f Type V (111) construction. Fated from Building 01 by by wall assemblies. The alarm system with smoke ridors and spaces open to the monitored for automatic fire tion. The facility has a and had a census of 47 at				
	A DOD ATON	/ DIDECTORIC OR PROCESS		THOS	TITLE		(VC) DATE

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

Electronically Signed

07/28/2015

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted July 24, 2015

Mr. Mark Rust, Administrator Buffalo Lake Health Care Center 703 West Yellowstone Trail, P.O. 368 Buffalo Lake, Minnesota 55314

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5589024

Dear Mr. Rust:

The above facility was surveyed on July 7, 2015 through July 9, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

Buffalo Lake Health Care Ctr July 24, 2015 Page 2

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulation Division

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

Enclosure (s)

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVI COMPLETED			
		00550	B. WING		07/09/2015
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NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA ST YELLOWSTO!	NE TRAIL, PO 368	
BUFFALO	LAKE HEALTH CARE C	ΓR	O LAKE, MN 55	•	
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2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	DRRECTION ORDER			
	144A.10, this correction pursuant to a survey. found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of whe corrected requires conceptive requirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any	ther a violation has been mpliance with all			
	You may request a he that may result from norders provided that a the Department within notice of assessment INITIAL COMMENTS You have agreed to preceipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic ure orders consistent with ment of Health 14-01, available at e.mn.us/divs/fpc/profinfo/inficensing orders are			

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

(X6) DATE TITLE

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMF	SURVEY
		00550	B. WING		07	/09/2015
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2 000	Department of Health you electronically. Al is necessary for State enter the word "correctext. You must then in State licensure proce completion date, the corrected prior to elect Minnesota Department on July 6-9, 2015 sustaff, visited the above correction orders are your electronic plan or reviewed these orders they will be completed. Minnesota Department the State Licensing Confederal software. Tag assigned to Minnesota Nursing Homes. The assigned tag nur column entitled "ID For statute/rule out of consummary Statement and replaces the "To correction order. This findings which are in after the statement, "evidence by." Following are the Suggested Matter Tomation of the State Column of the Suggested Matter the S	orders being submitted to though no plan of correction a Statutes/Rules, please cted" in the box available for idicate in the electronic ass, under the heading date your orders will be ctronically submitting to the int of Health. Inveyors of this Department's eleprovider and the following issued. Please indicate in a forrection that you have so, and identify the date when identify the date when identify the date when identify the date when interest in the far left in the interest in the state statutes/rules for interest in the state in the interest in	2 000			

Minnesota Department of Health

STATE FORM 6899 GIFX11 If continuation sheet 2 of 19

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D WING			
		00550	B. WING		07/09/2015	
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BUFFALO	LAKE HEALTH CARE C	TR	LAKE, MN 55	·		
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2 000	Continued From page	2	2 000			
		IREMENT TO SUBMIT A ION FOR VIOLATIONS OF STATUTES/RULES.				
2 560	MN Rule 4658.0405 S Plan of Care; Content	Subp. 2 Comprehensive ts	2 560			
	objectives and timetal long- and short-term of and mental and psychidentified in the compassessment. The commust include the indiv	of care must list measurable bles to meet the resident's goals for medical, nursing, nosocial needs that are rehensive resident mprehensive plan of care vidual abuse prevention plan a Statutes, section 626.557,				
	by: Based on interview, a facility failed to developlan to include access emergency procedure.	t is not met as evidenced and document review, the op a comprehensive care as site, special care, and es for 1 of 1 residents (R57) alysis at an outside facility.				
	Findings include:					
	3/24/15, identified R5 cognitively impaired, I	mum Data Set (MDS) dated 7 was moderately had end stage renal disease d hemodialysis at an outside				
	to dialysis three times of fistula (connection	d 7/7/15, identified she went a week, and had a history between an artery and vein complications. Further, the				

Minnesota Department of Health

STATE FORM 6899 GIFX11 If continuation sheet 3 of 19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		00550	B. WING		07	//09/2015
	ROVIDER OR SUPPLIER LAKE HEALTH CARE C	703 WES	DDRESS, CITY, STATE TYELLOWSTONE O LAKE, MN 5531	TRAIL, PO 368		
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2 560	including, "1500 cc [c restriction", "assist wi to and from dialysis a "Ensure dialysis completed, and read dialysis." However, the information or guidant R57 in an emergency scheduled dialysis appeare of the access sit and or signs and symidentify interventions risk for bleeding. During an interview of director on nursing (D not identify care of the in case of an emerge SUGGESTED METH director of nursing (D develop and implement related to care pland designee, could proving staff related to the time development. The quassurance committee ensure compliance.	everal interventions for R57 ubic centimeters] fluid th arranging transportation ppts [appointments]", and, munication form is upon [R57] return from ne care plan lacked any ce about how to care for plan if unable to make a pointment, monitoring and e (fistula) for complications ptoms of infection, and to reduce R57's elevated n 7/9/15, at 11:03 a.m. the pON) stated the facility did e access site, or what to do ncy for R57. OD OF CORRECTION: The ON) or designee, could ent policies and procedures evelopment. The DON or de training for all nursing neliness of care plan	2 560			
2 830	MN Rule 4658.0520 S Proper Nursing Care;	General	2 830			
		eneral. A resident must				

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER LAKE HEALTH CARE C	TR 703 WEST	PRESS, CITY, STA YELLOWSTON LAKE, MN 553	NE TRAIL, PO 368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	the comprehensive replan of care as descr 4658.0405. A nursing of bed as much as po written order from the	prervision based on preferences as identified in esident assessment and ribed in parts 4658.0400 and phome resident must be out essible unless there is a attending physician that the in bed or the resident	2 830			
	by: Based on observation review, the facility fail therapy (OT) recomm implemented to reduce edema and skin breat	te the risk of increased kdown for 1 of 1 residents edema glove, a device worn				
	5/8/15, identified R2 h impairment, neurologi extensive assistance and received no "splin restorative programm During observation or was seated in a high-	ical impairment, required with activities of daily living nt or brace assistance" ing during the review period. n 7/8/15, at 10:24 a.m. R2 back wheelchair in the				
	contractures in her let touching each other.	ing television. R2 had ft hand with her fingers There were no devices on decrease pressure between				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDIEAN	or dorace from	IDENTIFICATION NOMBER.	A. BUILDING: _		OOWII EETEB
		00550	B. WING		07/09/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
BUFFALO	LAKE HEALTH CARE C	TR 703 WEST	YELLOWSTON	NE TRAIL, PO 368	
DOTTALO	LAKE HEALTH SAKE S	BUFFALO	LAKE, MN 553	314	,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 830	Continued From page	: 5	2 830		
	devices, as they were time."				
	was seated in a reclin				
	R2 had brain damage identified as "contract Has worked with OT i splint, but none recon Further, the care plan	olan dated 6/12/15, identified due to anoxia with problem ure to left hand and fingers. In the past for possible mended at this time." Identified an intervention ocomplete, "Nursing rehabd by therapy/nursing."			
	Discharge Summary to identified, "The patient misalignment and Decof L [left] hand mult to be inappropriate. Esupport." Further, the has been instructed to				
		/8/15, at 6:47 p.m. nursing ed she was "not aware" of for her left hand.			
	stated R2's left hand las I've been here." F	7/9/15, at 8:16 a.m. NA-B had been the same, "as long urther, NA-B stated staff a day, but was unaware of ed on her left hand.			

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED
	00550	B. WING		07/09/2015
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BUFFALO LAKE HEALTH CARE CTR	BUFFALO I	LAKE, MN 553	314	
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 830 Continued From page 6		2 830		
During interview on 7/9/15 occupational therapist (OT started working at the facil dismissed from OT. R2 has for several years, and was in November 2014. R2 was with an established "wear edema glove being used to protect her skin. Nursing has keep the glove on, and a grompleted with staff to show the glove and care for it. It is should still be using the edema by the was unaware of for R2 to be using an edemo obviously didn't get the recommendation of the glove of nursing (DON) of had questioned using a but was unaware of any reformation or nursing being instructed Further, the DON stated if recommendations, it was a simplemented" as directed. When interviewed on 7/9/15 stated she had worked with to OT-A starting at the facil determined to need an edefingers apart" and prevent "That's what we want to prothey completed training with staff on the use of the glov programs be followed throst atted the edema glove she R2.	T)-A stated she just dility when R2 was ad a contracted hand is last seen by OT for it as dismissed from OT schedule" for an to reduce swelling and had been instructed to group training had been ow them how to apply Further, OT-A stated R2 dema glove as directed. 15, at 8:57 a.m. RN-A of OT's recommendation ma glove, adding, "We commendations." 5, at 9:06 a.m. the stated she was aware an edema glove for R2, eferral being completed d to use the glove. f OT had made expected "that its . 15, at 11:05 a.m. OT-B th R2 in the past, prior cility. R2 was lema glove to "keep the t skin breakdown, revent." OT-B stated ith some of the nursing ve, and expected "our ough." Further, OT-B	2 630		

Minnesota Department of Health STATE FORM

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	A. BUILDING: _		(X3) DATE SURVEY COMPLETED	
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CIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE	
page 7	2 830			
ng or designee, could review and and procedures related to erapy recommendations to and skin breakdown. They could cation, and the director of thee could develop an audit tool to ate care is provided.				
320 A.B.C Medication Errors	21545			
ation error rate is less than five ribed in the Interpretive ode of Federal Regulations, title 25 (m), found in Appendix P of ions Manual, Guidance to ng-Term Care Facilities, which is reference in part 4658.1315. For part, a medication error means: pancy between what was what medications are actually residents in the nursing home; or inistration of expired of any significant medication and medication error is: or which causes the resident or which causes the resident or ation from a category that usually dication in the resident's blood to				
A LAFICR — m Minane alugia F 1: E Cara Color Signatura Color S	ARE CTR TO3 WES BUFFAL MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION) TO page 7 METHOD OF CORRECTION: The ing or designee, could review and and procedures related to herapy recommendations to and skin breakdown. They could ducation, and the director of gnee could develop an audit tool to riate care is provided. FOR CORRECTION: Twenty-one 1320 A.B.C Medication Errors The must ensure that: cation error rate is less than five cribed in the Interpretive Code of Federal Regulations, title Code of Federal Regulations Code of Federal Regulations Code of Federal Regulations Code of Fede	ARE CTR TO3 WEST YELLOWSTON BUFFALO LAKE, MN 55: ARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL PREY OR LSC IDENTIFYING INFORMATION) TO page 7 METHOD OF CORRECTION: The ing or designee, could review and and procedures related to herapy recommendations to and skin breakdown. They could ducation, and the director of gnee could develop an audit tool to riate care is provided. FOR CORRECTION: Twenty-one 1320 A.B.C Medication Errors The must ensure that: cation error rate is less than five cribed in the Interpretive Code of Federal Regulations, title 1.25 (m), found in Appendix P of ations Manual, Guidance to cong-Term Care Facilities, which is reference in part 4658.1315. For s part, a medication error means: epancy between what was what medications are actually or residents in the nursing home; or ministration of expired To fany significant medication cant medication error is: fror which causes the resident expandizes the resident's health or facation from a category that usually dedication in the resident's blood to specific blood level and a single	ARE CTR STREET ADDRESS, CITY, STATE, ZIP CODE 703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314 ARY STATEMENT OF DEFICIENCIES TICHENCY MUST DE PRECEDED BY FULL RAPY STATEMENT OF DEFICIENCIES TICHENCY MUST DE PRECEDED BY FULL RAPY STATEMENT OF DEFICIENCIES TO PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY) IN page 7 2 830 METHOD OF CORRECTION: The ling or designee, could review and and procedures related to herapy recommendations to and skin breakdown. They could lucation, and the director of gnee could develop an audit tool to iate care is provided. FOR CORRECTION: Twenty-one 1320 A.B.C Medication Errors 21545 Provided in the Interpretive Code of Federal Regulations, title L25 (m), found in Appendix P of ations Manual, Guidance to ong-Term Care Facilities, which is or reference in part 4658.1315. For spart, a medication error means: epancy between what was what medications are actually or esidents in the nursing home; or ministration of expired of any significant medication ant medication error is: rror which causes the resident topardizes the resident's health or coation from a category that usually adication from the resident's blood to specific blood level and a single or could alter that level and	

Minnesota Department of Health

STATE FORM 6899 GIFX11 If continuation sheet 8 of 19

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	OLIMANA DV. OT		LAKE, MN 55		NI	
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21545	Continued From page	e 8	21545			
	prescribed. An incide error report must be f that occurs. Any sign resident reactions muphysician or the phys resident or the reside designated represent must be made in the C. All medication prescribed. An incide report must be filed fooccurs. Any significar resident reactions muphysician or the phys resident or the reside designated represent	ician's designee and the int's legal guardian or ative and an explanation resident's clinical record. Is are administered as ant report or medication error or any medication error that int medication errors or ast be reported to the ician's designee and the				
	by: Based on observation review, the facility fail were administered and manufacturer ins residents (R53, R38) medication during the					
		num Data Set (MDS) dated 3 had intact cognition.				
	for R53 on 7/9/15, at (RN)-A prepared two	medication administration 7:11 a.m. registered nurse separate medications, ation for thyroid disorder)				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SI COMPLE		
			71. 201231110.			
		00550	B. WING		07/0	9/2015
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
BUFFALO	LAKE HEALTH CARE C	TR	YELLOWSTON	NE TRAIL, PO 368 314		
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21545	Continued From page	9	21545			
	20 mg (milligrams) or cart in the commons a pills in a white medica them to R53 who was	on used to treat heartburn) le tablet for R53 at a mobile larea. RN-A placed the two lation cup, and administered lain bed.				
	identified an order of, [everyday]" RN-A and Administration Record 6/12/15 and only direct mg of omeprazole to telephone call to R53 clarification. At 10:38 the facility, and stated mg of omeprazole ea	on 7/9/15, at 10:22 a.m. and "Omeprazole 40 mg QD stated R53's Medication d (MAR) was updated on cted staff to administer 20 R53. RN-A placed a				
	R53 had received, "O CAPSULE Give 20	R dated 7/2015, identified MEPRAZOLE 20 MG mg by mouth one time a sysician order from 7/2/15 40 mg everyday.				
	had moderate cognitive physician orders date for, "Spiriva Respima [medication used to tree."	d 6/5/15, identified an order t Aerosol Solution reat bronchospasm and 2.5 mcg/act [actuation] 2				
	on 7/8/15, at 1:37 p.m (TMA)-A removed the	medication administration n. trained medication aide Spiriva Respimat inhaler the hallway. TMA-A entered				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF D	DOVIDED OD SLIDDI IED		DRESS, CITY, STA		1 07/09/2015	
	ROVIDER OR SUPPLIER	703 WEST		NE TRAIL, PO 368		
BUFFALO	LAKE HEALTH CARE C	TR	LAKE, MN 55	·		
(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 APPROPI DEFICIENCY)	BE COMPLETE	
21545	Continued From page	e 10	21545			
	R38's room, primed the approximately 2 inches While holding the devibutton to aerosolize the devices mouthpiece was causing the medication. TMA-A instructed R38 the medication which then provided him with afterwards. When introllowing the inhaler as she holds the inhaler "so [R38's] mouth does. The above observation 7/9/15, at 10:22 a.m. should be held "right when administered. The above gotten the powas held away from the RN-A stated this would medication error.	the device and held it es away from R38's mouth. Frice, TMA-A pressed the he medication while the was away from R38's mouth, on to mist into the air. It is to breath deeply to inhale was already in the air. She he a drink of water rerviewed immediately administration, TMA-A stated back away from the mouth esn't touch it." In was described to RN-A on who stated an inhaler up to their [resident] mouth the resident (R38) "would roper dosage" if the device his (R38's) mouth. Further, and be considered a lakage insert titled, Using at Inhaler dated 2015, ng is completed by,				
	lips around the end of	nd fully, and then close your f the mouthpiece"				
	director of nursing (Deshould be administered orders, and an inhale	/9/15, at 11:47 a.m. the ON) stated medication ed according to physician r needs to be administered eturer guidelines or it is "not"				
		ation policy dated 1/1/13, aff should verify that the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00550	B. WING		07/09/2015
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 07/09/2015
BUFFALO	LAKE HEALTH CARE C	TR		NE TRAIL, PO 368	
		BUFFALO	LAKE, MN 553		T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
21545	Continued From page	: 11	21545		
	Further, the policy dire manufacturer medical guidelines"				
	Director of Nursing ar review the facility's po- medication administra	OD OF CORRECTION: ad/or designee, could blicy and procedures for ation, and inservice/educate ection and appropriate			
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one			
21565	MN Rule 4658.1325 S Medications Self Adm	Subp. 4 Administration of in	21565		
	Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.				
	by: Based on observation review, the facility fail assess, care plan, and	t is not met as evidenced i, interview, and document ed to comprehensively d obtain physician orders ninistration of nebulizers for observed to receive			
	Findings include:				
	• • •	Physical dated 7/4/15, ementia" with "increased			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
00550		B. WING		07/09/2015		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		703 WEST	YELLOWSTON	NE TRAIL, PO 368		
BUFFALO	LAKE HEALTH CARE C	TR BUFFALO	LAKE, MN 553	314		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21565	Continued From page	e 12	21565			
	baseline confusion." R64's physician orders dated 7/8/15, identified an order for, "albuterol-ipratropium [inhaled medication used to relieve shortness of breath from chronic obstructive pulmonary disease] NEBULIZATION solutionInhale 3 ml [milliliters] via a nebulizer every 6 hours." R64's physician orders did not identify she could self administer any medications. R64's initial care plan dated 7/8/15, identified R64 was a new admission. The care plan did not identify if R64 was able to self administer her medications or not. During observation on 7/9/15, at 7:47 a.m. R64 was lying in bed with her eyes closed. R64 had a nebulizer machine running on her bedside					
	medication is aerosol resident) was lying no side. No visible medifrom the nebulizer. When interviewed on registered nurse (RN) nebulizer on her nose there currently was no in the nebulizer for R6)-A stated she placed R64's e and mouth, and identified o medication that remained				
	yesterday, and had not yet been assessed to determine if she was safe to self administer her own nebulizer treatments. Further, RN-A stated going forward R64 "would be one we would not have as a self administer [of medications]" because of the observed concern. She added she was unaware how much of the medication R64 had receive before she (R64) had removed the mask and laid it on the bed.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		00550	B. WING		07/0	9/2015
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BUFFALO	LAKE HEALTH CARE C	TR		NE TRAIL, PO 368		
			_AKE, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
21565	Continued From page	13	21565			
	includes an assessme a physicians order allo administer medication assessment is comple administer their own r DON stated R64 show with a nebulizer witho having a physician order A facility Self Administrated 5/10/10, identificomply with Facility pothe State Operations to resident Self-Admin The policy directed state determine whether medications is safe and	DN) stated the facility distration of medications ent for safety, and obtaining dowing them to self downed by the self downed by the self downed by the self downed by the self debulizers. Further, the define bulizers. Further, the define downed been left alone define obtained. The self define by				
	Director of Nursing (D review with staff curre residents who are self had been assessed a administer their own r physicians order for a could audit resident to	OD OF CORRECTION: The (ON) or designee could ent policies to ensure of administering medication and were appropriate to medication, along with a dministration. The DON of ensure assessment, and elf administration were in				
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING 07/09/2	ED						
A. BUILDING:							
00550 B. WING 07/09/2	2015						
00550 B. WING 07/09/2	2015						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
BUFFALO LAKE HEALTH CARE CTR BUFFALO LAKE, MN 55314 BUFFALO LAKE, MN 55314							
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)						
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	COMPLETE						
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE						
21830 Continued From page 14 21830							
21830 MN St. Statute 144.651 Subd. 10 Patients & 21830							
Residents of HC Fac.Bill of Rights							
Subd. 10. Participation in planning treatment;							
notification of family members.							
(a) Residents shall have the right to participate							
in the planning of their health care. This right							
includes the opportunity to discuss treatment and							
alternatives with individual caregivers, the							
opportunity to request and participate in formal care conferences, and the right to include a							
family member or other chosen representative or							
both. In the event that the resident cannot be							
present, a family member or other representative							
chosen by the resident may be included in such							
conferences.							
(b) If a resident who enters a facility is							
unconscious or comatose or is unable to							
communicate, the facility shall make reasonable							
efforts as required under paragraph (c) to notify							
either a family member or a person designated in writing by the resident as the person to contact in							
an emergency that the resident has been							
admitted to the facility. The facility shall allow the							
family member to participate in treatment							
planning, unless the facility knows or has reason							
to believe the resident has an effective advance							
directive to the contrary or knows the resident has							
specified in writing that they do not want a family							
member included in treatment planning. After							
notifying a family member but prior to allowing a							
family member to participate in treatment							
planning, the facility must make reasonable							
efforts, consistent with reasonable medical							
practice, to determine if the resident has executed an advance directive relative to the							

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esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00550		B. WING		07/09/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
BUFFALO LAKE HEALTH CARE CTR			YELLOWSTON LAKE, MN 553	NE TRAIL, PO 368 314	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21830	resident; (2) examining the normality member contact whether the resident in directive and whether physician to whom the care; and (4) inquiring of the resident normally goe whether the resident in directive. If a facility in designated emergency member to participate accordance with this pliable to resident for different the notification of the emergency contact or family member was in patient's privacy rights (c) In making reason family member or designated examining the person and the medical recordance with the facility shall atternate members or a designate examining the person and the medical recordance with the medical recordance with the medical recordance with the patient's privacy rights (c) In making reason family member or designate amining the person and the medical recordance with the medical recordance with the medical recordance with the patient with the patient with the privacy rights (c) In making reason family member or designate amining the person and the medical recordance with the privacy rights (c) In making reason family member or designate amining the person and the medical recordance with the privacy rights (c) In making reason family member or designate with the privacy rights (c) In making reason family member or designate with the privacy rights (c) In making reason family member or designate with the privacy rights (c) In making reason family member with the privacy rights (c) In making reason family member with the privacy rights (c) In making reason family member with the privacy rights (c) In making reason family member with the privacy rights (c) In making reason family member with the privacy rights (c) In making reason family member with the privacy rights (c) In making reason family member with the privacy rights (c) In making reason family member with the privacy rights (c) In making reason family member with the privacy rights (c) In making reason family member with the privacy rights (c) In making reason family member with the privacy rights (c) In making reason family me	personal effects of the medical records of the asion of the facility; emergency contact or ceted under this section has executed an advance of the resident has a ceresident normally goes for physician to whom the section for the facility member or contifies a family member or contact or allows a family ein treatment planning in paragraph, the facility is not family member or the participation of the inproper or violated the section of the member of the participation of the member of the participation of the member or the participation of the member or the participation of the member of the member of the member of the participation of the member of the	21830	DEPICIENCE	
	admission, the facility social service agency agency that the reside the facility has been unember or designate county social service enforcement agency s	ithin 24 hours after the shall notify the county or local law enforcement ent has been admitted and inable to notify a family d emergency contact. The agency and local law shall assist the facility in ng a family member or			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		l \ /	(X3) DATE SURVEY COMPLETED			
		00550	B. WING		07	7/09/2015		
			DDRESS, CITY, STATE	, ZIP CODE	,			
BUFFALC	LAKE HEALTH CARE C	TR	ST YELLOWSTONE O LAKE, MN 5531	•				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO		N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21830	designated emergency service agency or loc that assists a facility subdivision is not liab damages on the grouthe family member or	cy contact. A county social all law enforcement agency in implementing this le to the resident for nds that the notification of emergency contact or the mily member was improper	21830					
	This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure residents were given a choice of bathing preference for 1 of 3 residents (R50) who was able to make this choice. Findings include: R50's quarterly minimum data set (MDS) dated 5/11/15 indicated he was moderately cognitively impaired, and needed extensive assistance with transfers, ambulation and required assist of one staff for bathing. R50's admission MDS dated 8/15/14, identified he was alert and orientated, and it was very important to choose between a tub bath, shower, bed bath or sponge bath, but did not identify R50's preference.							
	alteration in self care	d 06/11/15, indicated an ability and required assist of but did not indicate a bathing						
	stated he receives a	on 7/7/15, at 3:26 p.m., R50 whirlpool bath each week given the choice to take a						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		A. BUILDING				
00550		B. WING		07/0	9/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
BUFFALO LAKE HEALTH CARE CTR			YELLOWSTON	NE TRAIL, PO 368		
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N.	(Y5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
21830	Continued From page	e 17	21830			
	shower. During a consecutive interview on 07/09/15, at 9:20 a.m., R50 stated he had not received a shower since admission, just baths. He further stated, "I would prefer a shower, its easier, but they don't have a shower that works. It would be nice to have a shower." During an interview on 7/9/15, at 7:55 a.m., the director of nursing (DON) stated resident's bathing preferences were assessed upon admission, during the activity assessment. She stated the facility offers a tub bath but residents could ask for a shower instead of a tub bath. The DON further stated the preference for bathing should have been listed on R50's care plan, and the facility has the ability to utilize showers throughout the building. During an interview on 07/09/15, at 8:00 a.m., registered nurse (RN)- B stated, the activity director (AD) asks the question regarding bathing preference and then will tell me if the resident has a preference. If a resident had a preference, she would put it on the care plan and it would be listed on the kardex for the nursing assistants.					
	AD stated she was th R50's assessment for routine. She stated sh are getting a bath in the	n 7/9/15, at 9:36 a.m., the e person who filled out repreferences for customary the "will tell the resident they he whirlpool and ask if they are was no indication R50 remarks instead of a bath.				
	During an interview on 7/9/15, at 10:25 a.m. NA-C stated, "Everyone gets a whirlpool bath" on the unit but residents have the option for a shower.					
	SUGGESTED METHOD OF CORRECTION:					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			OATE SURVEY COMPLETED	
		00550	B. WING		07	/09/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314						
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21830	The director of nursin review/revise policies resident choices. Empre-educated on these evaluating and monitor implementation of the developed, with the rebrought to the facility' Committee for review	g or designee, could and procedures related to bloyees could be policies. A system for bring consistent se policies could be esults of these audits being s Quality Assurance	21830			

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