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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GIFX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00550

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245589**

2.STATE VENDOR OR MEDICAID NO.
(L2) **090243800**

3. NAME AND ADDRESS OF FACILITY
(L3) **BUFFALO LAKE HEALTH CARE CTR**
(L4) **703 WEST YELLOWSTONE TRAIL, PO 368**
(L5) **BUFFALO LAKE, MN** (L6) **55314**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2009**

6. DATE OF SURVEY **08/27/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Austin Fry, HFE NE II 08/27/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 09/08/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS
Posted 09/29/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/11/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245589	A. Building B. Wing	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	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **08/18/2015**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **08/18/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **08/18/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/18/2015**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **08/18/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **08/18/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	09/08/2015	33925	08/27/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/9/2015			

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245589	01 - MAIN BUILDING 01	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	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 08/18/2015	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 08/18/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By GS/KJ	Date: 09/08/2015	Signature of Surveyor: 34764	Date: 09/08/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/8/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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	(Y2) Multiple Construction	(Y3) Date of Revisit
00550	A. Building B. Wing	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 Prefix **20560** Reg. # **MN Rule 4658.0405 Subp. 2** LSC	Correction Completed **08/18/2015**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **08/18/2015**	ID Prefix **21545** Reg. # **MN Rule 4658.1320 A.B.C** LSC	Correction Completed **08/18/2015**
ID Prefix **21565** Reg. # **MN Rule 4658.1325 Subp. 4** LSC	Correction Completed **08/18/2015**	ID Prefix **21830** Reg. # **MN St. Statute 144.651 Subd. 1** LSC	Correction Completed **08/18/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By (State Agency)	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/KJ	09/08/2015	33925	08/27/2015
Reviewed By (CMS RO)	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/9/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GIFX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00550

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245589**

2.STATE VENDOR OR MEDICAID NO.
(L2) **090243800**

3. NAME AND ADDRESS OF FACILITY
(L3) **BUFFALO LAKE HEALTH CARE CTR**
(L4) **703 WEST YELLOWSTONE TRAIL, PO 368**
(L5) **BUFFALO LAKE, MN** (L6) **55314**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2009**

6. DATE OF SURVEY **07/09/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Amy Charais, HFE NE II 08/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 08/07/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 08/11/2015 Co.
DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	07/09/2015

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

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, care plan, and obtain physician orders allowing safe self administration of nebulizers for 1 of 2 residents (R64) observed to receive inhaled medication. Findings include: R64's History & (and) Physical dated 7/4/15, identified R64 had "dementia" with "increased baseline confusion." R64's physician orders dated 7/8/15, identified an order for,	F 176	Preparation and execution of the response of the plan does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State Law require it. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction	8/18/15

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

Electronically Signed | 07/28/2015

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F 176	Continued From page 1 "albuterol-ipratropium [inhaled medication used to relieve shortness of breath from chronic obstructive pulmonary disease] ... NEBULIZATION solution ...Inhale 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 dresser, but the mask of the nebulizer (where medication is aerosolized and inhaled by the resident) was lying next to R64 in bed on her right side. No visible medication was being dispensed from the nebulizer. When interviewed on 7/9/15, at 7:50 a.m. registered nurse (RN)-A stated she placed R64's nebulizer on her nose and mouth, and identified there currently was no medication that remained in the nebulizer for R64 due to it being all dispensed. She stated R64 admitted to the facility 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. During interview on 7/9/15, at 8:03 a.m. the	F 176	constitutes the facility¿s allegation of compliance in accordance with section 7305 of the State Operations Manual F176 Completion Date: August 18, 2015 It is the intent of the Buffalo Lake Healthcare Center to allow individuals to self administer drugs if the interdisciplinary team feels the practice is safe. Resident R64 has been assessed and it has not been determined that she can consistently self administer her nebulizer. Other residents have been reviewed for determining their safety with self administration and changes made accordingly. Facility staff will be educated the week of August 10th on the need to determine safe self administration, care plan and obtain physician order prior to allowing residents to self administer any medication. The Director of Nursing or Designee will monitor for compliance with this process through random audits with focus on new admissions weekly x 4wks. Any problems or concerns with this plan will be brought to the attention of the QA team for changes and recommendations.	

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F 176	Continued From page 2 director of nursing (DON) stated the facility process for self administration of medications includes an assessment for safety, and obtaining a physicians order allowing them to self administer medication. No formal "typed out" assessment is completed for residents who self administer their own nebulizers. Further, the DON stated R64 should not have been left alone with a nebulizer without being assessed, and having a physician order obtained. A facility Self Administering Medications policy, dated 5/10/10, identified the facility "should comply with Facility policy, Applicable Law and the State Operations Manual [SOM] with respect to resident Self-Administration of medications." The policy directed staff to "assess and determine ... whether Self-Administration of medications is safe and appropriate", and, "ensure that orders for Self-Administration list the specific medication(s) the resident may Self-Administer."	F 176		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure residents were given a	F 242	F242 Completion Date: August 18, 2015 It is the intent of the Buffalo Lake	8/18/15

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F 242	Continued From page 3 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. R50's care plan dated 06/11/15, indicated an alteration in self care ability and required assist of one staff for bathing but did not indicate a bathing preference. During and interview on 7/7/15, at 3:26 p.m., R50 stated he receives a whirlpool bath each week and had never been given the choice to take a 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	F 242	Healthcare Center for all residents to choose the type of bathing preference they would like. Resident R50 was interviewed for his bathing preference and his Kardex updated with his choice. All residents will be interviewed and their reported bathing preference added to the Kardex for staff to access for bathing. Facility staff will be educated on the need to follow the resident preference with the understanding that the resident can change their mind at any time and their wish is to be followed. The Director of Nursing or Designee will monitor for compliance with the process through random audits on a weekly basis x 4 and then quarterly with resident care conferences. Any concerns will be brought to the QA committee for recommendations.	

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F 242	Continued From page 4 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. During an interview on 7/9/15, at 9:36 a.m., the AD stated she was the person who filled out R50's assessment for preferences for customary routine. She stated she "will tell the resident they are getting a bath in the whirlpool and ask if they are okay with it." There was no indication R50 was offered a shower 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.	F 242		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		8/18/15

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F 279	Continued From page 5 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop a comprehensive care plan to include access site, special care, and emergency procedures for 1 of 1 residents (R57) who received hemodialysis at an outside facility. Findings include: R57's admission Minimum Data Set (MDS) dated 3/24/15, identified R57 was moderately cognitively impaired, had end stage renal disease (ESRD), and received hemodialysis at an outside facility. R57's care plan, dated 7/7/15, identified she went to dialysis three times a week, and had a history of fistula (connection between an artery and vein used to start dialysis) complications. Further, the care plan identified several interventions for R57 including, "1500 cc [cubic centimeters] fluid restriction", "assist with arranging transportation to and from dialysis appts [appointments]", and, "Ensure dialysis communication form is completed, and read upon [R57] return from dialysis." However, the care plan lacked any information or guidance about how to care for	F 279	F 279 Completion Date: August 18, 2015 It is the intent of the Buffalo Lake Healthcare Center to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident¿s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. R 57¿s care plan has been updated to include information on how to care for R57 and an emergency plan if unable to make dialysis, monitoring and care of the access site, and interventions to reduce the elevated risk of bleeding. There are no other residents currently in the facility receiving dialysis. Facility staff have been educated on the requirements under F279 related to dialysis care. The Director of Nursing or Designee will review the care plan for dialysis residents	

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F 279	Continued From page 6 R57 in an emergency plan if unable to make a scheduled dialysis appointment, monitoring and care of the access site (fistula) for complications and or signs and symptoms of infection, and identify interventions to reduce R57's elevated risk for bleeding. During an interview on 7/9/15, at 11:03 a.m. the director on nursing (DON) stated the facility did not identify care of the access site, or what to do in case of an emergency for R57.	F 279	to be sure it is updated with the necessary information. Any concerns or problems will be brought to the QA team for recommendations.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure occupational therapy (OT) recommendations were implemented to reduce the risk of increased edema and skin breakdown for 1 of 1 residents (R2) who utilized an edema glove, a device worn to provide compression. Findings include: R2's quarterly Minimum Data Set (MDS) dated 5/8/15, identified R2 had severe cognitive impairment, neurological impairment, required	F 309	F 309 Completion Date: August 18, 2015 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 or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. R2 has been referred by the physician for OT to evaluate for appropriate restorative programming.	8/18/15

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F 309	Continued From page 7 extensive assistance with activities of daily living and received no "splint or brace assistance" restorative programming during the review period. During observation on 7/8/15, at 10:24 a.m. R2 was seated in a high-back wheelchair in the commons area watching television. R2 had contractures in her left hand with her fingers touching each other. There were no devices on her left hand, to help decrease pressure between her fingers. When interviewed on 7/8/15, at 10:44 a.m. registered nurse (RN)-A stated R2 had a contracture of her left hand, but did not wear any devices, as they were "not recommended at this time." During observation on 7/8/15, at 3:23 p.m. R2 was seated in a recliner chair in her room watching TV. R2 did not have any devices on her left hand. Review of R2's care plan dated 6/12/15, identified R2 had brain damage due to anoxia with problem identified as "contracture to left hand and fingers. Has worked with OT in the past for possible splint, but none recommended at this time." Further, the care plan identified an intervention which directed staff to complete, "Nursing rehab program as developed by therapy/nursing." Review of R2's OT Therapist Progress & (and) Discharge Summary form dated 11/7/14, identified, "The patient [R2] exhibits joint misalignment and Decreased [sp] motor control of L [left] hand ... multiple splints have been found to be inappropriate. Edema glove to be worn for support." Further, the note identified, "Nursing	F 309	All resident cases will be reviewed and referred to OT if needed, all resident PT/OT/rehab notes will be reviewed to ensure therapy recommendations were implemented as directed. Therapy staff and nursing staff will be educated on the facility process for setting up a resident on a restorative program to ensure programs are completed as recommended. The Director of Nursing or Designee will monitor for compliance with this process on a weekly basis with therapy rounds. Any concerns will be brought to the attention of the QA committee for review and recommendations.	

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F 309	Continued From page 8	F 309		

has been instructed to use edema glove for finger separation and to assist in cleanliness of L hand."

During interview on 7/8/15, at 6:47 p.m. nursing assistant (NA)-A stated she was "not aware" of any devices R2 used for her left hand.

When interviewed on 7/9/15, at 8:16 a.m. NA-B stated R2's left hand had been the same, "as long as I've been here." Further, NA-B stated staff wash her hand twice a day, but was unaware of any devices being used on her left hand.

During interview on 7/9/15, at 8:47 a.m. the occupational therapist (OT)-A stated she just started working at the facility when R2 was dismissed from OT. R2 had a contracted hand for several years, and was last seen by OT for it in November 2014. R2 was dismissed from OT with an established "wear schedule" for an edema glove being used to reduce swelling and protect her skin. Nursing had been instructed to keep the glove on, and a group training had been completed with staff to show them how to apply the glove and care for it. Further, OT-A stated R2 should still be using the edema glove as directed.

When interviewed on 7/9/15, at 8:57 a.m. RN-A stated she was unaware of OT's recommendation for R2 to be using an edema glove, adding, "We obviously didn't get the recommendations."

During interview on 7/9/15, at 9:06 a.m. the director of nursing (DON) stated she was aware OT had questioned using an edema glove for R2, but was unaware of any referral being completed or nursing being instructed to use the glove. Further, the DON stated if OT had made recommendations, it was expected "that its

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F 309	Continued From page 9 implemented" as directed. When interviewed on 7/9/15, at 11:05 a.m. OT-B stated she had worked with R2 in the past, prior to OT-A starting at the facility. R2 was determined to need an edema glove to "keep the fingers apart" and prevent skin breakdown, "That's what we want to prevent." OT-B stated they completed training with some of the nursing staff on the use of the glove, and expected "our programs be followed through." Further, OT-B stated the edema glove should still be worn by R2.	F 309		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were administered according to physician orders and manufacturer instructions for 2 of 10 residents (R53, R38) observed to receive medication during the survey. This resulted in a facility medication error rate of 8% (percent). Findings include: R53's quarterly Minimum Data Set (MDS) dated 4/10/15, identified R53 had intact cognition. During observation of medication administration for R53 on 7/9/15, at 7:11 a.m. registered nurse	F 332	F 332 Completion Date: August 18, 2015 It is the intent of the Buffalo Lake Healthcare Center to ensure medication errors do not occur. The order for R53 was corrected during the survey when it was identified. The staff were corrected on the proper procedure for the inhaler for R38 during the survey. All staff will be re-educated the week of August 10, 2015 on proper medication administration to prevent medication errors.	8/18/15

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F 332	Continued From page 10 (RN)-A prepared two separate medications, levothyroxine (medication for thyroid disorder) 112 mcg (micrograms) one tablet and omeprazole (medication used to treat heartburn) 20 mg (milligrams) one tablet for R53 at a mobile cart in the commons area. RN-A placed the two pills in a white medication cup, and administered them to R53 who was in bed. R53's physician orders dated 7/2/15, were reviewed with RN-A on 7/9/15, at 10:22 a.m. and identified an order of, "Omeprazole 40 mg QD [everyday] ..." RN-A stated R53's Medication Administration Record (MAR) was updated on 6/12/15 and only directed staff to administer 20 mg of omeprazole to R53. RN-A placed a telephone call to R53's physician seeking clarification. At 10:38 a.m. R53's physician called the facility, and stated R53 should be getting 40 mg of omeprazole each day. RN-A stated R53 had been given the incorrect dose of omeprazole, "That is an error." "Review of R53's MAR dated 7/2015, identified R53 had received, "OMEPRAZOLE 20 MG CAPSULE ... Give 20 mg by mouth one time a day...", despite the physician order from 7/2/15 directing staff to give 40 mg everyday. R38's quarterly MDS dated 4/3/15, identified R38 had moderate cognitive impairment. R38's physician orders dated 6/5/15, identified an order for, "Spiriva Respimat Aerosol Solution [medication used to treat bronchospasm and shortness of breath] 2.5 mcg/act [actuation] ... 2 puff inhale orally one time a day..." During observation of medication administration	F 332	The Director of Nursing or Designee will monitor for compliance with this process through weekly observation/audits x4. Further observation/audits will be completed by the pharmacy consultant on a quarterly basis and reported to the QA committee for any recommendations.	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 11	F 332		

on 7/8/15, at 1:37 p.m. trained medication aide (TMA)-A removed the Spiriva Respimat inhaler from a mobile cart in the hallway. TMA-A entered R38's room, primed the device and held it approximately 2 inches away from R38's mouth. While holding the device, TMA-A pressed the button to aerosolize the medication while the devices mouthpiece was away from R38's mouth, causing the medication to mist into the air. TMA-A instructed R38 to breath deeply to inhale the medication which was already in the air. She then provided him with a drink of water afterwards. When interviewed immediately following the inhaler administration, TMA-A stated she holds the inhaler back away from the mouth "so [R38's] mouth doesn't touch it."

The above observation was described to RN-A on 7/9/15, at 10:22 a.m. who stated an inhaler should be held "right up to their [resident] mouth" when administered. The resident (R38) "would not have gotten the proper dosage" if the device was held away from his (R38's) mouth. Further, RN-A stated this would be considered a medication error.

The manufacture package insert titled, Using Your Spiriva Respimat Inhaler dated 2015, identified correct dosing is completed by, "Breathe out slowly and fully, and then close your lips around the end of the mouthpiece..."

During interview on 7/9/15, at 11:47 a.m. the director of nursing (DON) stated medication should be administered according to physician orders, and an inhaler needs to be administered according to manufacturer guidelines or it is "not going to be effective."

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	245589	A. BUILDING _____ B. WING _____	07/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 12 A facility General Dose Preparation and Medication Administration policy dated 1/1/13, identified, "Facility staff should verify that the medication name and dose are correct..." Further, the policy directed staff to, "Follow manufacturer medication administration guidelines..."	F 332		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that medication labels were correct for 2 of 10 residents (R57, and R25) medication labels observed.	F 425	F 425 Completion Date: August 18, 2015 It is the intent of the Buffalo Lake Healthcare Center to provide routine and emergency drug and biologicals to its	8/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BUFFALO LAKE HEALTH CARE CTR	703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314

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F 425	Continued From page 13 Findings include: Review of R57's physician orders dated 3/17/15, identified an order for, "Omeprazole Capsule [medication used for heart burn] Delayed Release 20 mg [milligrams] ... Give 20 mg by mouth one time a day for Heartburn..." During observation of medication administration on 7/8/15, at 5:25 p.m. TMA-A removed a package of Omeprazole from a mobile cart to administer to R57, and provided it to the surveyor for review. The medication label identified, "1 TAB BY MOUTH EVERY MORNING - TAKE 15 - 30 MINUTES BEFORE A MEAL." TMA-A stated R57's Medication Administration Record (MAR) directs staff to administer the medication in the evening, and the time for administration on the label (every morning)was inaccurate. When interviewed on 7/8/15, at 5:29 p.m. LPN-A stated R57's Omeprazole had been given "before supper", and the medication was mis-labeled. Further, LPN-A stated she needed to "update the pharmacy with new orders" adding it so "there is no medication error." R57's admission Minimum Data Set (MDS) dated 3/24/15, identified R57 was moderately cognitively impaired, had end stage renal disease (ESRD), and received hemodialysis from an outside dialysis center. R57's Physician's Order Summary Report, dated 6/2/15, identified an order for, "Lidocaine and Prilocaine cream [medication cream used to reduce pain during needle insertion for dialysis] 2.5% [percent] - 2.5% to fistula site prior to	F 425	residents and ensure that medication labels are correct for residents. For R57 the omeprazole directions change stickers have been applied to the medication to indicate that the MAR is the order staff are to follow and the pharmacy has been updated with the correct directions to be applied to future medication. The Lidocaine and Prilocaine 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.	

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	245589	A. BUILDING _____ B. WING _____	07/09/2015

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F 425	Continued From page 14	F 425		

dialysis. Cover with Saran wrap. Done the night before dialysis at bedtime (Mon-Wed-Fri)."

During observation of medication storage on 7/8/15, at 3:53 p.m. R57's tube of Lidocaine and Prilocaine cream was in a mobile medication cart. The medication label identified the following instructions, "... apply small amount to access site 1 to 2 hours before dialysis. Cover with occlusive dressing (saran wrap)." Further, the label identified the order had been written by R57's primary nephrologist, medical doctor (MD)-E.

When interviewed on 7/8/15, at 8:01 p.m. R57 stated she sometimes would have pain when the dialysis needles were inserted adding, "Someday's it hurts more than others." Staff had been putting a medicated cream on her arm the night before dialysis since she admitted to the facility.

During interview on 7/9/15, at 10:21 a.m. R57's dialysis registered nurse (RN)-K stated R57's Lidocaine cream should be applied 1-2 hours prior to her dialysis treatment, and that applying the cream the night before would "be totally pointless."

When interviewed on 7/10/15, at 10:47 a.m. the pharmacy consultant (PC) stated R57's medicated cream should be applied "2-3 hours" before dialysis "to be most effective."

During telephone interview on 7/10/15, 11:10 a.m. MD-E (R57's nephrologist) stated nursing home staff should be following the prescribed order and applying the medicated cream to R57's arm 1-2 hours prior to dialysis. Further, MD-E added applying the cream the night before would "make

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F 425	Continued From page 15	F 425		

no sense."

R25's physician orders dated 6/30/15, identified an order for, "Senna-S [medication used to relieve constipation] 8.6-50 mg [milligrams] ... Give 1 tablet by mouth one time a day..."

During observation of medication administration on 7/8/15, at 5:55 p.m. trained medication aide (TMA)-A removed a bottle of Senna from a mobile cart to administer to R25, and provided it to the surveyor for review. The medication label identified, "GIVE 2 TABS BY MOUTH IN THE EVENING." TMA-A stated R25 had a new order for her Senna a couple weeks prior, and the label was not changed to alert staff. Further, TMA-A stated the label should have had a sticker placed on it directing staff to refer to the current physician orders "so mistakes aren't made."

When interviewed on 7/8/15, at 6:00 p.m. licensed practical nurse (LPN)-A stated R25's Senna order was changed on 6/29/15, and should have had a sticker placed on the label to identify the change.

During interview on 7/9/15, at 11:30 a.m. the dispensing pharmacist (DP) stated the medications should have had a sticker placed on them to alert staff to the changes in orders, as their is potential for error if they were not labeled correctly.

When interviewed on 7/9/15, at 11:47 a.m. the director of nursing (DON) stated the medication labels should have had a sticker placed on them to direct staff to refer to the physician orders, "To alert the med [medication] person to know the label is not correct."

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	245589	A. BUILDING _____ B. WING _____	07/09/2015

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F 425	Continued From page 16 A facility medication labeling policy was requested, but none was provided.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/08/2015**

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

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K 000	INITIAL COMMENTS	K 000		

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 01 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 19 Existing Health Care Occupancies.

Building 01 of Buffalo Lake Healthcare Center was constructed as follows:
The original building was constructed in 1960, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction;
The 1st Addition was constructed in 1965, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction;
The 2nd Addition was constructed in 1982, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction;
The 3rd Addition was constructed in 1993, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction.

Building 01 is separated from both Building 02, and an attached assisted living facility, 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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/08/2015**

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K 000	Continued From page 1 time of the survey.	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY STANDARD - Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. NFPA 101 (00), Chapter 19, Section	K 018	K 018 Completion Date: August 18, 2015 It is the intent of the Buffalo Lake Healthcare Center to maintain all corridor doors in the means of egress in accordance with NFPA 101 (2000) Chapter 19, Section 19.3.6.3. The Administrator and Maintenance Supervisor will be responsible for maintaining the corridors doors in the means of egress so that they positively latch into the frame.	8/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/08/2015**

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BUFFALO LAKE HEALTH CARE CTR	**703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314**

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K 018	Continued From page 2 19.3.6.3. This STANDARD is not met as evidenced by: Based upon observation, the facility had a corridor door which was impeded from fully closing and latching into its frame. In a fire emergency, this deficient practice could adversely affect 47 of 49 residents, staff and visitors due to the location of this linen room. FINDINGS INCLUDE: On 07/08/2015 at 2:30 PM, observation revealed the corridor door to the clean linen room #7 did not positively latch into its frame because the latch was removed. This deficient practice was verified by the Maintenance Supervisor (RH) and Administrator (MR)	K 018	A new latch has been ordered and will be installed on the corridor door to the clean linen room #7.	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, electrical installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition. section 9.1.2. This deficiency could negatively effect the 30 of 49 residents. Findings include: On facility tour between 12:30 PM and 3:30 PM on 07/08/2015, it was observed: 1. There was an extension cord plugged into a refrigerator in the Administrator's office.	K 147	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. All extension cords will be removed from	8/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/08/2015**

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BUFFALO LAKE HEALTH CARE CTR	**703 WEST YELLOWSTONE TRAIL, PO 368** **BUFFALO LAKE, MN 55314**

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K 147	Continued From page 3 2. There was an extension cord plugged into a power strip in the business office. 3. RM 204 had an air conditioner plugged into an extension cord. 4. Break Room had a Microwave plugged into an extension cord. This deficient practice was verified by Maintenance Supervisor (RH) and the Administrator (MR).	K 147	service. An electrician is installing additional electrical outlets in the office, room 204 and break room.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING **02 - 2012 BUILDING ADDITION** B. WING _____	**07/08/2015**

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

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K 000	INITIAL COMMENTS	K 000		

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/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:

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00550	A. BUILDING: _____ B. WING _____	07/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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	2 000		

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	00550	A. BUILDING: _____ B. WING _____	07/09/2015

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On July 6-9, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to develop a comprehensive care plan to include access site, special care, and emergency procedures for 1 of 1 residents (R57) who received hemodialysis at an outside facility. Findings include: R57's admission Minimum Data Set (MDS) dated 3/24/15, identified R57 was moderately cognitively impaired, had end stage renal disease (ESRD), and received hemodialysis at an outside facility. R57's care plan, dated 7/7/15, identified she went to dialysis three times a week, and had a history of fistula (connection between an artery and vein used to start dialysis) complications. Further, the	2 560		

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2 560	Continued From page 3 care plan identified several interventions for R57 including, "1500 cc [cubic centimeters] fluid restriction", "assist with arranging transportation to and from dialysis appts [appointments]", and, "Ensure dialysis communication form is completed, and read upon [R57] return from dialysis." However, the care plan lacked any information or guidance about how to care for R57 in an emergency plan if unable to make a scheduled dialysis appointment, monitoring and care of the access site (fistula) for complications and or signs and symptoms of infection, and identify interventions to reduce R57's elevated risk for bleeding. During an interview on 7/9/15, at 11:03 a.m. the director on nursing (DON) stated the facility did not identify care of the access site, or what to do in case of an emergency for R57. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan development. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan development. The quality assessment and assurance committee could perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and	2 830		

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2 830	Continued From page 4 custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure occupational therapy (OT) recommendations were implemented to reduce the risk of increased edema and skin breakdown for 1 of 1 residents (R2) who utilized an edema glove, a device worn to provide compression. Findings include: R2's quarterly Minimum Data Set (MDS) dated 5/8/15, identified R2 had severe cognitive impairment, neurological impairment, required extensive assistance with activities of daily living and received no "splint or brace assistance" restorative programming during the review period. During observation on 7/8/15, at 10:24 a.m. R2 was seated in a high-back wheelchair in the commons area watching television. R2 had contractures in her left hand with her fingers touching each other. There were no devices on her left hand, to help decrease pressure between her fingers.	2 830		

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2 830	Continued From page 5 When interviewed on 7/8/15, at 10:44 a.m. registered nurse (RN)-A stated R2 had a contracture of her left hand, but did not wear any devices, as they were "not recommended at this time." During observation on 7/8/15, at 3:23 p.m. R2 was seated in a recliner chair in her room watching TV. R2 did not have any devices on her left hand. Review of R2's care plan dated 6/12/15, identified R2 had brain damage due to anoxia with problem identified as "contracture to left hand and fingers. Has worked with OT in the past for possible splint, but none recommended at this time." Further, the care plan identified an intervention which directed staff to complete, "Nursing rehab program as developed by therapy/nursing." Review of R2's OT Therapist Progress & (and) Discharge Summary form dated 11/7/14, identified, "The patient [R2] exhibits joint misalignment and Decreased [sp] motor control of L [left] hand ... multiple splints have been found to be inappropriate. Edema glove to be worn for support." Further, the note identified, "Nursing has been instructed to use edema glove for finger separation and to assist in cleanliness of L hand." During interview on 7/8/15, at 6:47 p.m. nursing assistant (NA)-A stated she was "not aware" of any devices R2 used for her left hand. When interviewed on 7/9/15, at 8:16 a.m. NA-B stated R2's left hand had been the same, "as long as I've been here." Further, NA-B stated staff wash her hand twice a day, but was unaware of any devices being used on her left hand.	2 830		

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2 830	Continued From page 6 During interview on 7/9/15, at 8:47 a.m. the occupational therapist (OT)-A stated she just started working at the facility when R2 was dismissed from OT. R2 had a contracted hand for several years, and was last seen by OT for it in November 2014. R2 was dismissed from OT with an established "wear schedule" for an edema glove being used to reduce swelling and protect her skin. Nursing had been instructed to keep the glove on, and a group training had been completed with staff to show them how to apply the glove and care for it. Further, OT-A stated R2 should still be using the edema glove as directed. When interviewed on 7/9/15, at 8:57 a.m. RN-A stated she was unaware of OT's recommendation for R2 to be using an edema glove, adding, "We obviously didn't get the recommendations." During interview on 7/9/15, at 9:06 a.m. the director of nursing (DON) stated she was aware OT had questioned using an edema glove for R2, but was unaware of any referral being completed or nursing being instructed to use the glove. Further, the DON stated if OT had made recommendations, it was expected "that its implemented" as directed. When interviewed on 7/9/15, at 11:05 a.m. OT-B stated she had worked with R2 in the past, prior to OT-A starting at the facility. R2 was determined to need an edema glove to "keep the fingers apart" and prevent skin breakdown, "That's what we want to prevent." OT-B stated they completed training with some of the nursing staff on the use of the glove, and expected "our programs be followed through." Further, OT-B stated the edema glove should still be worn by R2.	2 830		

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2 830	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to implementing therapy recommendations to prevent edema and skin breakdown. They could provide staff education, and the director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or	21545		

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toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.

C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure medications were administered according to physician orders and manufacturer instructions for 2 of 10 residents (R53, R38) observed to receive medication during the survey. This resulted in a facility medication error rate of 8% (percent).

Findings include:

R53's quarterly Minimum Data Set (MDS) dated 4/10/15, identified R53 had intact cognition.

During observation of medication administration for R53 on 7/9/15, at 7:11 a.m. registered nurse (RN)-A prepared two separate medications, levothyroxine (medication for thyroid disorder)

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112 mcg (micrograms) one tablet and omeprazole (medication used to treat heartburn) 20 mg (milligrams) one tablet for R53 at a mobile cart in the commons area. RN-A placed the two pills in a white medication cup, and administered them to R53 who was in bed.

R53's physician orders dated 7/2/15, were reviewed with RN-A on 7/9/15, at 10:22 a.m. and identified an order of, "Omeprazole 40 mg QD [everyday] ..." RN-A stated R53's Medication Administration Record (MAR) was updated on 6/12/15 and only directed staff to administer 20 mg of omeprazole to R53. RN-A placed a telephone call to R53's physician seeking clarification. At 10:38 a.m. R53's physician called the facility, and stated R53 should be getting 40 mg of omeprazole each day. RN-A stated R53 had been given the incorrect dose of omeprazole, "That is an error."

"Review of R53's MAR dated 7/2015, identified R53 had received, "OMEPRAZOLE 20 MG CAPSULE ... Give 20 mg by mouth one time a day...", despite the physician order from 7/2/15 directing staff to give 40 mg everyday.

R38's quarterly MDS dated 4/3/15, identified R38 had moderate cognitive impairment. R38's physician orders dated 6/5/15, identified an order for, "Spiriva Respimat Aerosol Solution [medication used to treat bronchospasm and shortness of breath] 2.5 mcg/act [actuation] ... 2 puff inhale orally one time a day..."

During observation of medication administration on 7/8/15, at 1:37 p.m. trained medication aide (TMA)-A removed the Spiriva Respimat inhaler from a mobile cart in the hallway. TMA-A entered

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21545	Continued From page 10 R38's room, primed the device and held it approximately 2 inches away from R38's mouth. While holding the device, TMA-A pressed the button to aerosolize the medication while the devices mouthpiece was away from R38's mouth, causing the medication to mist into the air. TMA-A instructed R38 to breath deeply to inhale the medication which was already in the air. She then provided him with a drink of water afterwards. When interviewed immediately following the inhaler administration, TMA-A stated she holds the inhaler back away from the mouth "so [R38's] mouth doesn't touch it." The above observation was described to RN-A on 7/9/15, at 10:22 a.m. who stated an inhaler should be held "right up to their [resident] mouth" when administered. The resident (R38) "would not have gotten the proper dosage" if the device was held away from his (R38's) mouth. Further, RN-A stated this would be considered a medication error. The manufacture package insert titled, Using Your Spiriva Respimat Inhaler dated 2015, identified correct dosing is completed by, "Breathe out slowly and fully, and then close your lips around the end of the mouthpiece..." During interview on 7/9/15, at 11:47 a.m. the director of nursing (DON) stated medication should be administered according to physician orders, and an inhaler needs to be administered according to manufacturer guidelines or it is "not going to be effective." A facility General Dose Preparation and Medication Administration policy dated 1/1/13, identified, "Facility staff should verify that the medication name and dose are correct..."	21545		

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21545	Continued From page 11 Further, the policy directed staff to, "Follow manufacturer medication administration guidelines..." SUGGESTED METHOD OF CORRECTION: Director of Nursing and/or designee, could review the facility's policy and procedures for medication administration , and inservice/educate pertinent staff for correction and appropriate monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, care plan, and obtain physician orders allowing safe self administration of nebulizers for 1 of 2 residents (R64) observed to receive inhaled medication. Findings include: R64's History & (and) Physical dated 7/4/15, identified R64 had "dementia" with "increased	21565		

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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 solution ...Inhale 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 dresser, but the mask of the nebulizer (where medication is aerosolized and inhaled by the resident) was lying next to R64 in bed on her right side. No visible medication was being dispensed from the nebulizer.

When interviewed on 7/9/15, at 7:50 a.m. registered nurse (RN)-A stated she placed R64's nebulizer on her nose and mouth, and identified there currently was no medication that remained in the nebulizer for R64 due to it being all dispensed. She stated R64 admitted to the facility 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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21565	Continued From page 13 During interview on 7/9/15, at 8:03 a.m. the director of nursing (DON) stated the facility process for self administration of medications includes an assessment for safety, and obtaining a physicians order allowing them to self administer medication. No formal "typed out" assessment is completed for residents who self administer their own nebulizers. Further, the DON stated R64 should not have been left alone with a nebulizer without being assessed, and having a physician order obtained. A facility Self Administering Medications policy, dated 5/10/10, identified the facility "should comply with Facility policy, Applicable Law and the State Operations Manual [SOM] with respect to resident Self-Administration of medications." The policy directed staff to "assess and determine ... whether Self-Administration of medications is safe and appropriate", and, "ensure that orders for Self-Administration list the specific medication(s) the resident may Self-Administer." SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review with staff current policies to ensure residents who are self administering medication had been assessed and were appropriate to administer their own medication, along with a physicians order for administration. The DON could audit resident to ensure assessment, and physician orders for self administration were in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00550	A. BUILDING: _____ B. WING _____	07/09/2015

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21830	Continued From page 14	21830		
21830	MN St. Statute 144.651 Subd. 10 Patients & 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 esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:	21830		

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21830	Continued From page 15 (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or	21830		

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21830	Continued From page 16 designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. 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. R50's care plan dated 06/11/15, indicated an alteration in self care ability and required assist of one staff for bathing but did not indicate a bathing preference. During and interview on 7/7/15, at 3:26 p.m., R50 stated he receives a whirlpool bath each week and had never been given the choice to take a	21830		

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21830	Continued From page 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.

During an interview on 7/9/15, at 9:36 a.m., the AD stated she was the person who filled out R50's assessment for preferences for customary routine. She stated she "will tell the resident they are getting a bath in the whirlpool and ask if they are okay with it." There was no indication R50 was offered a shower 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:

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21830	Continued From page 18 The director of nursing or designee, could review/revise policies and procedures related to resident choices. Employees could be re-educated on these policies. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		