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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HGI3

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 **10/13/2021** (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

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 :
Karen Aldinger, Unit Supervisor 10/31/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/31/2021 (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)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 31, 2021

CMS Certification Number (CCN): 245589

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

Dear Administrator:

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

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

Effective October 31, 2021 the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically Delivered

October 31, 2021

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

RE: CCN: 245589
Cycle Start Date: August 12, 2021

Dear Administrator:

On October 13, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HGI3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00550

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(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 **08/12/2021** (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

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From (a) :
To (b) :

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

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 09/20/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/20/2021 (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)

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21. 1. Statement of Financial Solvency (HCFA-2572)
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3. Both of the Above :
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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)

DETERMINATION APPROVAL

Electronically delivered
September 9, 2021

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

RE: CCN: 245589
Cycle Start Date: August 12, 2021

Dear Administrator:

On August 12, 2021, a 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

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

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

If substantial compliance with the regulations is not verified by November 12, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by February 12, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

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

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

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

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

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

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

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	08/12/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/9/21 to 8/12/21, a survey for compliance with CMS Appendix Z Emergency Preparedness Requirements was completed during a recertification survey. Buffalo Lake Healthcare Center was found in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 8/9/21 to 8/12/21, a standard recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Buffalo Lake Healthcare Center was found not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. 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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		10/31/21

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

Electronically Signed | 09/17/2021

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

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 _____	08/12/2021

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 689	Continued From page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess after falls, place care planned interventions based upon an assessment and follow care planned interventions to prevent falls for 1 of 3 residents (R9) reviewed for falls. Findings Include: R9's annual Minimum Data Set (MDS) dated 5/17/21, included, moderate cognitive impairment with diagnoses including Alzheimer's disease, anxiety and psychotic disorder. R9 required extensive assistance with most activities of daily living (ADL's) and was unsteady without human assistance. R9's care plan dated 6/3/21, included risk for falling and directed staff to use antirollback device on wheel chair and grip tape on the floor. R9's Kardex Report (nurse aide worksheet) also instructed staff to use a bed alarm, chair alarm, a low bed, keep nightstand and other furniture away from bed to prevent injury, grippy socks and if in bed, to keep wheelchair within reach in case she attempted to self transfer. R9's Fall Summary dated 7/7/21, included, "Found resident sitting on the floor next to her bed holding turn handle with both hands and had her head wedged between the turn handle and the bed mattress." R9's Fall Risk Assessment dated 7/7/21, identified she was at high risk for	F 689	It is the intent of the Buffalo Lake Healthcare Center to comprehensively assess residents after a fall, place care plan interventions, and follow care plan interventions to prevent falls. A comprehensive fall risk assessment and analysis has been completed on the resident involved and the resident's care plan that has been reviewed and updated to reflect all current interventions being utilized. All residents have the potential to be affected by this practice. All resident care plans will be reviewed and updated to reflect the current fall interventions. Education will be completed with all licensed staff. The facility policy is to ensure that a comprehensive Fall Risk Assessment is completed after each fall with new interventions put into place to prevent falls. This policy will be reviewed with training completed by October 13, 2021. All fall documentation will be reviewed by the Director of Nursing/Designee within 3days of the fall and referred to the falls QIPP team for any further recommendations on a weekly basis. Weekly audits will be completed x 4 and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2 falls, and to continue the interventions as care planned. No comprehensive assessment of this fall was documented, nor were new interventions were placed. R9's Fall summary dated 7/22/21, indicated resident found laying on the floor in [a different resident's room] by the bed. Her shoes were off and her glasses were on the nightstand so it appeared that she was attempting to lay down in that bed. Found with head towards the foot of the bed on her right side. Resident unable to give description. R9's Fall Risk Assessment dated 7/22/21, identified she was at high risk for falls. "Resident was attempting to lay down on a bed as she had her shoes and glasses off. Alarm was going off but staff could not find her at first as she was in another resident's room." Under, "Interventions put in place," was, "has alarms." No comprehensive assessment of this fall was documented, nor were other interventions placed following this fall to prevent it from happening again. During interview on 8/9/21, at 2:16 p.m. R9 confirmed falling but denied getting her head stuck between the assist rail (turn handle) and mattress. During interview on 8/10/21, at 2:00 p.m. the director of nursing (DON) stated that with the fall on 7/7/21, R9's head was not wedged and stated that was miscommunication as her head was never stuck. DON stated it was a, "bad choice of words." During observation on 8/10/21, at 4:51 p.m. R9 was sitting in her recliner, her wheel chair was 4 feet away from her. It had not been placed within	F 689	then monthly x 4, or until full compliance is achieved, to ensure care plan interventions are being followed. Any concerns will be brought to the quality assurance team for review and further guidance for continued improvement.	

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 _____	08/12/2021

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 689	Continued From page 3	F 689		

R9's reach.

During observation on 8/11/21, at 7:10 a.m. R9 was laying in bed, her wheelchair was 4-5 feet away from her bed.

During observation on 8/11/21, at 7:24 a.m. R9 was laying in bed, her wheel chair was 4-5 feet away from her.

When interviewed on 8/11/21, at 8:00 a.m. nursing assistant (NA)-A stated R9 was at risk for falls and the wheelchair was to be placed away from resident. NA-A consulted the Kardex and then stated, "Oh, that is right, we switched it back and her wheelchair is to be close to her to prevent her from falling when she self-transfers." NA-A confirmed R9's wheelchair was not next to her, but across the room.

When interviewed on 8/11/21, at 8:09 a.m. licensed practical nurse (LPN)-B stated, R9's wheelchair should be next to her bed as she self transfers and is at risk for falls. LPN-B confirmed that wheelchair was not next to resident and stated, "I would think its not where is should be and that it was important to be next to the bed to prevent her from falling." LPN-B moved wheelchair next to residents bed. LPN-B stated that with each fall they should be assessing the resident and figuring out why they fell or how they fell and then discuss ways to prevent further falls.

When interviewed on 8/11/21, at 8:43 a.m. NA-B stated R9 was, "antsy," and at risk for falls, so her wheelchair should be next to her. NA's use the Kardex to know how to care for residents.

When interviewed on 8/11/21, at 9:56 a.m.

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registered nurse (RN)-A stated, it was important to follow the care planned interventions for R9 to help prevent her from falling. If a resident falls, the nurse checks for injury and starts the fall report, and should add interventions based upon an analysis of the fall. RN-A was unable to find an analysis of the falls which R9 had on 7/7/21 or 7/22/21, and no new interventions had been placed.

When interviewed on 8/11/21, at 10:50 a.m. the DON stated when residents fall, the nurse should assess the resident, and update the care plan if needed. Staff discuss falls on a weekly basis. The DON confirmed no comprehensive assessment of R9's falls on 7/7/21 and 7/22/21, were completed and no new interventions had been placed to assist in preventing falls for R9. The DON stated R9's care plan should have been followed and staff should have placed R9's wheel chair close to her at all times.

Resident incident/accident assessment and documentation related to falls policy reviewed 2/20, included, "The intent of this policy is to establish guidelines and procedures that adequately identify, assess, treat, and prevent incidents and accidents that put the resident at risk for injury. All incidents will be evaluated and assessed immediately to ensure that immediate treatment and intervention(s) are initial elements of the accident/incident process. After the initial steps of assessment and treatment have been completed, the ID team shall attempt to determine the root cause(s) of the incident and the best approach(s) to prevent reoccurrence for the resident. Trends an patterns will also be identified as part of the total quality improvement

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F 689	Continued From page 5 process for the accident/incident policy and procedure. Effectiveness and Efficacy of both current and preventative measures shall be a component of the quality improvement system." Resident care planning procedure policy reviewed 3/21, indicated "each resident has resident care plan that is current, individualized and consistent with the medical regimen. Each discipline is responsible for following the established format for care planning of the LTC (long term care) facility."	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess new onset pain for 1 of 2 residents (R20) reviewed for pain management. Findings include: R20's annual Minimum Data Set dated 6/14/21, indicated no cognitive impairment and required extensive assistance with bed mobility and transfers. and dressing, independent with eating, and R20 did not have pain during the assessment period. R20's facesheet printed 8/11/21, indicated	F 697	It is the intent of the Buffalo Lake Healthcare Center to ensure that a comprehensive pain management plan is provided to residents who require such services. Pain monitoring was put in place for the identified resident during the survey. This practice has the potential to affect all residents. The nursing team will review all resident to ensure that pain monitoring and assessment is in place for those that require it with ongoing comprehensive assessment as indicated.	10/31/21

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F 697	Continued From page 6 diagnosis of unspecified intracranial injury without loss of consciousness, low back pain, other chronic pain, and unspecified osteoarthritis, unspecified cite. R20's Pain Management Assessment dated 6/14/21, indicated, R20 denied having pain in last 5 days, and had not used any prn (as needed) medications. R20's care plan dated 6/28/21, indicated needs pain management and monitoring related to diagnosis of osteoarthritis, diabetic neuropathy, chronic pain. should assess, record, and report to MD as needed for signs of distress or pain unrelieved by ordered treatment and medication. administer medications as ordered, and anticipate resident' need for pain relief and respond as soon as possible to any complaint of pain. R20's medication orders for pain printed 8/11/21, included; Aspercream lotion 10% apply to back topically every 4 hours as needed for pain. started 7/28/21. Neurontin (helps with nerve pain) Capsule 400 mg give 1 capsule by mouth three times a day related to type 2 diabetes mellitus with diabetic neuropathy. started 12/28/14. Tramadol (pain medication) give 50 mg by mouth at bed time related to low back pain started 9/16/20. Tylenol (pain reliever) give 1000 mg by mouth three times a day for pain related to low back pain and osteoarthritis and chronic pain started 12/21/18. Tylenol 325 mg given 650 mg by mouth every 4 hours as needed for pain do not exceed 4000 mg in a 24 hour period started 6/24/20. Voltaren gel 1% apply to left great toe topically every 4 hours as needed for pain started	F 697	Education will be completed with all licensed staff. The facility policy to ensure comprehensive pain management is provided for all residents, especially those with a new onset of pain, will be reviewed. Education will be completed by October 13, 2021. The DON/designee will audit the pain management program weekly x 4 and then monthly x 4 or until full compliance is achieved. Any concerns will be brought to the quality assurance team for review and further guidance for continued improvement.	

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7/28/21. Voltaren gel 1% apply to left shoulder and elbow topically every 4 hours as need for pain may use up to 4 times a day 4 grams per application started 7/28/21.

R20's progress notes on 7/23/21, at 6:20 p.m. indicated R20 reported right lower abdominal pain. resident received Dulcolax (to promote stool) on day shift and so far no results. R20 was encouraged to drink plenty of fluids.

R20's progress notes on 7/24/21, at 10:00 pm indicated R20 reported right side pain worsening and during EZ stand (standing lift to transfer a resident from sit to stand or stand to sit) resident frowning and moaning.

R20's progress note dated 7/25/21, at 5:59 a.m. resident was given as needed Tylenol with minimal relief due to right abdomen pain.

R20's progress notes dated 7/25/21, at 6:38 a.m. resident continued to report severe pain and tenderness in the right abdomen. Resident was sent to emergency room for evaluation.

R20's progress note dated 7/25/21, at 12:19 p.m. indicated R20 returned from Hutchinson Health emergency room via ambulance with diagnosis pancreatic mass, renal arterial aneurysm, hepatic cirrhosis and unspecified whether ascites present. No new orders were provided.

R20's ER After Visit Summary and CT report dated 7/25/21, indicated visit for abdominal pain and cirrhosis was given hydromorphone (narcotic pain reliever) at 7:33 a.m. with new diagnoses including abdominal pain, right lower quadrant, pancreatic mass, renal arterial aneurysm, and

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hepatic cirrhosis.

R20's progress note dated 7/30/21, at 6:21 a.m. indicated R20 reported right abdomen pain was offered Tylenol overnight but declined.

During observation on 8/10/21, at 5:34 p.m. LPN-V went into residents room to administer insulin and resident reported pain. LPN-V did not address pain and said the nurse just gave him Tylenol. There was no follow up if tylenol was effective.

During interview on 8/10/21, at 5:39 p.m. R20 stated that he gets a sharp shooting pain when he goes from sitting to standing in his lower abdomen. R20 stated his pain was a 7 out of 10 in severity (moderate to severe).

During interview on 8/11/21, at 7:21 a.m. R20 stated pain was good today and tolerable but does shoot up when he goes from standing to sitting or sitting to standing. R20 reported he did tell staff about the pain.

During interview on 8/11/21, at 8:14 a.m. licensed practical nurse (LPN)-B stated R20 had been sent to the ER on 7/25/21, for right side abdominal pain due to severe pain and, he, "could hardly move." LPN-B stated R20 returned with diagnosis of pancreatic mass and has been getting prn Tylenol and Ultram nightly and indicated the provider did not change any of his pain medication after the visit. LPN-B stated she was unsure if a pain assessment was completed but should be if new pain exist. LPN-B further stated it was important to monitor pain every shift

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as no one should have to be in pain.

During interview on 8/11/21, at 9:56 a.m. registered nurse (RN)-A stated that R20 came back from the ER 7/25/21, due to having new onset of right abdominal pain with a diagnosis of cirrhosis of liver, renal aneurysm, pancreatic mass but thought the pain was due to his insulin injections. RN-A stated that R20's provider came in and addressed the CT but no orders pertaining to his right sided pain noted. RN-A stated R20 had reported abdomen pain last night and just started the comprehensive pain assessment now but did not start it for the right side pain back in July. RN-A confirmed that is should of been started with any new complaints of pain to monitor if improving or not. RN-A stated that if a resident reported pain it should be charted. No documented assessment of this new onset pain had been completed after he had returned from the ER on 7/25/21.

During interview on 8/11/21, at 10:50 p.m. director of nursing (DON) stated, R20 went out to the ER in July due to new onset of right sided abdominal pain and came back with a diagnosis of pancreatic mass and that he also reports toe pain which his provider addressed on 7/28/21. No monitoring of this new onset pain was completed or assessments post ER visits to follow up on residents pain from visit to ER in 7/25/21. DON stated they did start the pain assessment this morning as resident reported pain again on the overnight shift. DON stated she was not aware of the diagnosis of pancreatic mass until the doctor came on 7/28/21. The DON stated, R20 should have had pain monitoring as it was a new pain for the resident. DON stated it was important to monitor and assess pain as no one should have

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F 697	Continued From page 10 to be in pain. Pain management policy and procedure dated 11/19, indicated "It is the policy of this facility to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident goals and preferences. The facility assessment will include review of expressions of pain, which may be verbal or nonverbal and are subjective. A resident may avoid the use of the term "pain". Complete a pain interview and/or implement pain monitoring with a new diagnosis or condition change that may be contributing factor to pain."	F 697		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the	F 791		10/31/21

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F 791	Continued From page 11 dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure identified dental concerns were addressed and referred to an appropriate service for care and treatment for 1 of 1 residents (R35) reviewed for dental care. Findings include: R35's quarterly Minimum Data Set (MDS), dated 7/12/21, identified R35 had moderate cognitive impairment and required extensive assistance to complete her personal hygiene. In addition, R35's Census Profile, printed 8/11/21, identified R35's payer source as Medicaid with an effective date of 1/20/21.	F 791	It is the intent of the Buffalo Lake Healthcare Center to assist residents in obtaining routine and 24hour emergency dental care. A dental appointment has been made for the resident identified. All residents have the potential to be affected and all resident records will be reviewed and appointments set up as need determined. The facility policy will be reviewed with all licensed staff and medical records to	

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F 791	Continued From page 12 R35's admission Oral-Dental Assessment/Bathing Preference assessment, dated 1/22/20, identified R35 had broken or loose natural teeth along with " ... obvious or likely cavity/cavities." R35 did not wear any dentures, and the assessment outlined R35 denied oral pain or difficulty chewing at the time. However, a subsequent section labeled, "Dentist," outlined R35 wished to see a dentist along with a radio-button style question which read, "Does resident need a dental referral per nursing assessment?" This was answered, "Yes." R35's care plan, dated 7/13/21, identified R35 had potential for dental-related complications and had her own teeth with " ... many missing, and others in the lower front which are worn down and in bad condition." A goal was listed on the care plan which read, "[R35] will be/remain free of infection, pain or bleeding in the oral cavity through [review date]," along with several interventions to help R35 meet this goal. These interventions included providing assistance with oral cares and helping to coordinate appointments or transportation for dental care as needed. On 8/9/21, at 10:18 a.m. R35 was interviewed and explained she had some teeth which were broken or missing. R35 showed the surveyor her teeth which affirmed her statement along with identified visible food particles and a light white-colored substance along the gum line of several of her lower teeth. R35 voiced she was unsure when she had last seen the dentist for her teeth; however, she added it was "not recently." R35 expressed her family member, (FM)-A, had been helping to set-up her financial assistance	F 791	ensure ongoing needs are met. Education will be provided by October 13, 2021. The DON/Designee will review all appointments quarterly at resident care conference and ensure appointments are offered and set up as needed.	

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and she desired the see the dentist for her teeth as they "sometimes" caused her pain when eating.

R35's subsequent progress notes, dated 10/26/20 to 8/5/21, identified the following recorded entries:

On 10/26/20, an MDS note was entered which outlined, "Resident has her own natural teeth, which are in poor condition ... did agree to seeing a dentist. Writer informed medical records. Resident's [FM-A] isin [sic] the process of signing resident on with MA [Medicaid]. Medical records going to check on progress and determine payer source and where to schedule resident an appointment."

On 12/28/20, an MDS note was entered which outlined, "[R35] does have her own teeth, and states she has been having difficulty with chewing. Would not give details regarding this. Medical records is aware of need for dental [appointment] as able to schedule per family."

On 1/12/21, an MDS note was entered which outlined, "Resident has natural teeth in poor condition. Likely cavities. Resident denied any mouth/facial pain or difficulty with chewing."

However, R35's medical record was reviewed and lacked evidence R35 had been referred to a dentist for her dental concerns despite being identified upon her admission assessment (dated 1/2020) as desiring and needing a dental referral for her teeth, and several subsequently recorded progress notes outlining her teeth as being in poor condition and, at times, expressing difficulty with chewing.

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When interviewed on 8/11/21, at 8:11 a.m. trained medication aide (TMA)-A explained R35 needed "total assist" for cares including oral hygiene. TMA-A stated she was aware R35's teeth "aren't in the greatest condition" as she had noticed they're not white anymore and "sometimes they have stuff in them" and "build up" present. TMA-A stated she was unable to recall last when, or if, R35 had seen a dentist since she admitted to the nursing home.

On 8/11/21, at 9:13 a.m. a telephone call was placed to FM-A. FM-A stated they were unable to speak about R35's care right then and they would call back later in the day. A return call was not received during the recertification survey.

On 8/11/21, at 9:20 a.m. registered nurse (RN)-A was interviewed. RN-A reviewed R35's medical record and verified her admission oral assessment outlined R35 had requested to see a dentist, and the nurse who completed the assessment identified R35 warranted referral to a dental provider for her teeth. RN-A voiced she was unaware what action, if any, had been taken to help coordinate a dental examination for R35 since she admitted to the nursing home. RN-A then contacted the medical records personnel and verified R35 was on Medicaid; however, the personnel were unable to recall if they ever attempted to coordinate or obtain a dental appointment for R35. RN-A stated she suspected R35's dental appointment and need to be seen had likely "got lost in the shuffle" with the pandemic; however, RN-A acknowledged the nursing home had resumed normal dental-related appointments several months ago. RN-A stated R35's dental appointment and needs should have

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been addressed sooner to help reduce the risk of tooth pain and because if someone has dental-related issues they "need to be taken care of."

On 8/11/21, at 1:43 p.m. the director of nursing (DON) and licensed social worker (LSW)-A were interviewed. They had reviewed R35's medical record and explained R35's dental-related notes and documentation started when the nursing home was "hot and heavy" in the pandemic; however, they acknowledged more normal dental care appointments had resumed several months prior. They explained there had been some issues in the past with coordinating care and appointments with FM-A; however, they voiced the facility had never contacted him, to their knowledge, about arranging to coordinating a dental examination for R35. The DON stated coordinating dental appointments for person(s) on Medicaid could be difficult, at times, with a lack of providers willing to accept these patients; however, she acknowledged the coordination process and appointment could have been started sooner to ensure R35's dental issues and needs were addressed.

A facility policy on dental care visits was requested; however, was not received.

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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
K 000	INITIAL COMMENTS FIRE SAFETY An Annual Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Buffalo Lake Healthcare Center Building 01 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. 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. The 4th & 5th Addition was constructed 2012 and 2014 resident room additions, is one-story, has no basement, is fully sprinklered and was determined to be of Type V (111) construction and is properly separated by a two-hour fire wall assembly. The above additions have been surveyed as one building. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the	K 000		

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

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 _____	**08/12/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 corridors which is monitored for automatic fire department notification. The facility has a capacity of 49 beds and had a census of 41 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING **03 - 2 ADDITION / REMODEL** B. WING _____	**08/12/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY An Annual Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Buffalo Lake Healthcare Center Building 03 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Buffalo Lake Healthcare Center added an addition in 2020 which was added to the 2014 resident room addition to add on 2 more rooms and a remodel was completed to the entrance/lobby, community room, multi-purpose room, activity room, canopy, office and new generator was installed outside. It was determined to be a Type V (000) Construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 49 beds and had a census of 41 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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