Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2024

Administrator
Buffalo Lake Health Care Center
703 West Yellowstone Trail
Buffalo Lake, MN 55314

RE: CCN: 245589
Cycle Start Date: December 20, 2023

Dear Administrator:

On January 17, 2024, we notified you a remedy was imposed. On March 4, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 28, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 20, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 17, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 20, 2024, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 28, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies. Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 10, 2024

Administrator
Buffalo Lake Health Care Center
703 West Yellowstone Trail
Buffalo Lake, MN 55314

RE: CCN: 245589
Cycle Start Date: December 20, 2023

Dear Administrator:

On December 20, 2023, 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Sassen, BSN, RN
Regional Operations Supervisor
St. Cloud Team A
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: Nicole.Sassen@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 March 20, 2024 (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 June 20, 2024 (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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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

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 ______	12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUFFALO LAKE HEALTH CARE CENTER	**703 WEST YELLOWSTONE TRAIL** **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 12-18-23 through 12-20-23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/18/2024

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

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F 000	INITIAL COMMENTS On 12-18-23 through 12-20-23, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580		2/23/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/18/2024

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

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F 580	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify a provider of a drop in blood pressure for 1 of 1 residents (R4) reviewed for orthostatic blood pressure (a measure of blood	F 580	It is the intent of the Buffalo Lake Healthcare Center to promptly notify providers of a resident change of condition.	

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F 580 Continued From page 2

pressure before and after a change in position).

Findings include:

R4's face sheet printed 12/20/23, noted diagnoses included hypertension and type 2 diabetes mellitus.

R4's signed physician's orders dated 12/6/23, included an order to check orthostatic blood pressure (blood pressure checked first when lying, then sitting, then standing) every four weeks. The order failed to provide instructions for updating the physician.

Review of R4's orthostatic blood pressure results 10/2023-12/2023 were as follows:
- 10/8/23 lying 154/89, sitting 147/54
- 11/5/23 sitting 167/74, standing 94/48
- 12/3/23 lying 138/65, sitting 151/112

R4's nurse notes for 10/2023 thru 12/20/23 failed to note changes in R4's orthostatic blood pressures or action taken as a result.

On 12/20/23 at 9:23 a.m., R4's primary provider stated she did not recall being notified of the change in R4's blood pressure on 11/5/23, if she had, she would have made changes to R4's medications. She expected to be notified with any change in condition, including orthostatic blood pressures with a 20 point or greater drop in the systolic blood pressure (top number- measurement taken when the pressure on the walls of the artery is at the highest).

On 12/20/23 at 11:13 a.m., registered nurse (RN)-A explained the process to check orthostatic blood pressure included initially checking the

F 580

The provider for R4 was notified of the orthostatic blood pressure of concern during the survey and medication adjustments were made.

All residents have the potential to be affected by this practice and orthostatic blood pressure monitoring is being reviewed on all residents to determine the necessity and parameters added to the orders to indicate when to notify the provider.

Education on properly obtaining orthostatic blood pressures, as well as, when provider notification is necessary will be conducted with licensed nurses and trained medication aids. Policy review and training will be completed by February 23, 2024.

The Director of Nursing/Designee will monitor all blood pressures on a weekly basis x 4 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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F 580	Continued From page 3	F 580		

blood pressure while the resident is lying, then have the resident sit up for at least one minute before checking the blood pressure again, finally have the resident stand for at least one minute before checking the blood pressure for a third time. If the resident is unable to remain in either the sitting or standing position it is acceptable to check the blood pressure after only one change in position. The purpose of the orthostatic blood pressure was to monitor for a drop in the systolic. RN-A considered a "big drop" to be 10-15 points. If a "big drop" occurred, RN-A would update the charge nurse and document in the residents record if there were signs of dizziness, feeling faint or unsteady and what the actions were taken. When asked to review R4's orthostatic blood pressures from 11/5/23, RN-A stated R4's provider should have been notified of this drop as it was a big drop and was concerning. RN-A noted there was no documentation is R4's nurse notes regarding the change in blood pressure or actions.

On 12/20/23 at 11:29 a.m., director of nurse (DON) stated a change of 20 points or great in the systolic blood pressure, the provider should have been updated. DON left it up to the nurse completing the orthostatic blood pressure to decide if they blood pressure should be rechecked later. DON expected the results and actions taken following the results were documented in the nurses' notes. DON confirmed there were not nurse notes in R4's record regarding the orthostatic blood pressures taken on 11/5/23. The facility did not have a policy that provided direction for rechecking orthostatic blood pressure. With R4's history of falls, the different from sitting to standing was concerning as it could increase R4's risk for falling.

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F 580	Continued From page 4 Facility policy titled Change of Condition-Physician, Resident, Family/Responsible Party Notification with a review date 10/2023, instructed to notify the physician any time there is a change in condition.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the	F 583		2/2/24

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F 583	Continued From page 5 Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure confidentiality of health conditions for 1of 1 residents (R42) who was reviewed for right to privacy. Findings include: R42's admission MinimumData Set (MDS) dated 4/7/23, identified resident as having intact cognition and frequent incontinence of bowel and bladder. R42's order summary report dated 12/20/23, indicated resident was taking Vancomycin (an antibiotic medication) for enterocolitis (inflammation of the inner lining of the small intestine and colon) due to clostridium Difficile (C. diff- an infection in the colon). R42's care plan dated 12/18/23 indicated the potential for complications r/t (C.diff) and instructed staff contact precautions were in place due to C. diff infection. During observations 12/18/23 at 2:33 p.m., 12/19/23 at 9:24 a.m., and 12/20/23 at 8:56 a.m., a cart with personal protective (PPE) supplies was present in the hall outside R42's room door and signage was hung on the outside of R42's door. The hung signage included the type of isolation precautions staff should use when entering the resident room for cares, how to don and doff PPE, and to stop and check with the	F 583	It is the intent of the Buffalo Lake Healthcare Center to ensure privacy and confidentially for all residents. The signage that was outside of R42s room was immediately removed once identified during the survey. Since that time this resident is now off precautions, and all signage has been removed. All residents have the potential to be affected by this practice. New binders have been added to each PPE cart to give guidance to staff placing a person in precautions clear direction on which signage to post for the different types of precautions. Education on the new binders will be provided to licensed staff and completed by February 2, 2024. The Director of Nursing/Designee will monitor for compliance with privacy and confidentiality and postings weekly x 4, 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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F 583	Continued From page 6 nurse before entering. One posted sign on the door was titled "Contact Precautions" with instructions to remove the sign after the room was cleaned and listed "Common conditions" and "If patient has diarrhea (C. difficile) use contact enteric precautions" highlighted in yellow. Posted on the wall in the hall next to R42's door was a typed paper sign titled "Reminders for C. Diff Precautions" and included bullet points regarding where residents should shower and use the bathroom. When interviewed on 12/20/23 at 8:11 AM, trained medication aide (TMA)-A stated when a resident need to be on isolation protocol is to place a cart with PPE outside the room and to put signage on the door directing staff which type of precautions to use during cares depending on which infection the resident had. The signage should include the type of precautions necessary to assist with resident cares. When interviewed on 12/20/23 at 9:07 a.m., the director of nursing (DON) stated when isolation precautions are implemented for a resident with an active infection the charge nurse placed the carts and signage. The signage should instruct staff to the type of precautions to use, the PPE necessary for cares and should not indicate the specific infection the resident has. The DON reviewed the signage on R42's door and confirmed the two signs specifying C. diff were visible to other residents and visitors to the facility and did not need to be there. The DON stated there was a verbal and written shift report system where staff were notified of the type of infection a resident had and their personal information should be protected from those who did not need to know.	F 583		

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F 583	Continued From page 7 The facility policy "Transmission Based Precautions Policy and Procedure Buffalo Lake Healthcare Center" dated October 2023, identified "Signage can either indicate the CDC category of Transmission-based Precautions" and "must comply with resident's rights to confidentiality and privacy."	F 583		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy	F 625		2/2/24

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 ______	12/20/2023

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

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F 625	Continued From page 8 described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the resident or their representative a written bed hold policy at the time of hospital transfer for 2 of 2 residents (R24 and R40) who was reviewed for hospitalization. Findings include: R24's significant change Minimum Data Set (MDS) dated 10/31/23, indicated R24 had moderately impaired cognition. R24's progress notes indicated R24 was hospitalized on 10/3/23 and returned to the facility on 10/12/23. R24 was re-hospitalized on 10/18/23 and returned to the facility on 10/25/23. R24's medical record lacked evidence a bed hold was provided at the time of transfer for either hospitalization. R40's MDS dated 11/20/23, indicated R40 had moderately impaired cognition. R40's progress notes indicated R40 was hospitalized on 10/3/23 and returned to the facility on 10/9/23. R40's medical record lacked evidence a bed hold was provided at the time of transfer for hospitalization. During an interview on 12/20/23 at 9:40 a.m., the director of nursing (DON) expected when a resident was transferred out of the facility a bed hold was initiated by the charge nurse and was	F 625	It is the intent of the Buffalo Lake Healthcare Center to provide each resident or resident representative notice of the facility bed hold policy and return. This practice has the potential to affect all residents. A new form has been developed to indicate who the bed hold was discussed with at the time of transfer and a structured progress note for transfer/discharge updated to include the bed hold information. A checklist will be created to remind staff of what information is to be included at the time of a transfer or discharge. The facility policy was reviewed and updated accordingly. Education will be provided to all licensed staff on the bed hold policy and how properly document the bed hold was provided. Training will be completed by February 2, 2024. The Director of Nursing/Designee will monitor for compliance with Bed Hold being provided weekly x 4, then monthly x 4 or until full compliance is achieved. Any concerns will be brought to the attention of the quality assurance team for review and further guidance for continued improvement.	

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F 625	Continued From page 9 sent with to the hospital. DON stated she expected the social worker to follow up to determine if the resident wanted to continue holding the bed. If staff had asked the resident and or family it would be documented in the progress notes. DON confirmed that she could not find communication with the resident and or family in regard to a bed hold for R24 or R40's hospitalizations. During interview on 12/20/23 at 9:45 a.m. DON stated she followed up with her social worker to see what exactly the process was with the social worker stating when a bed hold was sent with the resident, SW assumed that the resident wanted their bed held and did not follow up the following day to discuss. DON stated it is important for the resident and/or family to be aware and have a written notice of a bed hold so they are aware of what they may have to pay for and that they have a spot to come back to. A facility policy titled "Bed Hold and Return to Facility with a date of 3/2017, identified the resident or their representative will be provided with bed hold and return information at admission and before a hospital transfer or therapeutic leave. The facility will maintain in contact with the resident and representative while the resident is absent from the facility and arrange for their return if appropriate. Nursing and social work staff are educated about the resident's bed hold and return rights to ensure that required information is provided at the time the resident leave the facility. The facility will provide the resident or resident representative a written notice which specifies the duration of the bed-hold policy at the time of transfer for hospitalization or therapeutic leave. In cases or	F 625		

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F 625	Continued From page 10 emergency transfer, notice at the time of transfer means that the facility will send the notice along with the necessary paperwork to the receiving setting and the resident representative will be notified the next business day. The social worker will contact the resident or the representative on the next business day to ensure that they understand the bed hold and return to facility information. Documentation of bed hold notice will be filed in the individual medical record.	F 625		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or	F 883		2/23/24

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F 883	Continued From page 11 refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R26, R31 and R40) reviewed for immunizations were offered and/or provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include:	F 883	It is the intent of the Buffalo Lake Healthcare Center to ensure that all residents are offered and provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC). The vaccine has been offered and provided to those involved in the deficient practice through shared clinical decision	

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F 883	Continued From page 12 A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 65 years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. R26's face sheet, dated 12/20/23, indicated he was 77 years old. The immunization record, dated 12/20/23, indicated he received a PPSV23 on 6/22/2012 followed by the PCV13 on 10/17/2014. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R26 was offered or received PCV20. R31's face sheet, dated 12/20/23, indicated she was 90 years old. The immunization record, dated 12/20/23, indicated she received a PCV13 on 10/14/2007 followed by a PCV13 on 9/25/2013 and a PCV13 on 10/30/2015. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R31 was offered or received PCV20. R40's face sheet, dated 12/20/23, indicated he was 89 years old. The immunization record, dated 12/20/23, indicated he received a PCV13 on 10/31/2006 followed by a PCV13 on	F 883	making. This practice has the potential to affect all residents of the facility. The newest guidelines from the CDC have been reviewed and applied to each resident. Providers for all residents will be consulted through shared clinical decision making to determine how to proceed for each resident. Vaccine consents are being obtained and vaccine administered as recommended by the provider. The consent form for pneumococcal vaccine has been updated to also reflect the PCV20 at the time admission. Going forward the MDS nurse and IP will evaluate the need for PCV 20 during the admission process. Anyone that is in need of the PCV20 will be reviewed through shared clinical decision making to determine if vaccine is to be administered and the vaccine will be given accordingly. Anyone that is not in the window to receive the PCV20 will be tracked by the IP for review and administration when the vaccine is due. The Director of Nursing/IP will monitor for compliance through record review by February 23, 2024 and annually in the fall ongoing. Any concerns with compliance will be brought to the attention of the quality assurance committee for further direction and guidance.	

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F 883	Continued From page 13	F 883		

11/22/2011 and a PCV13 on 8/22/2017. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R40 was offered or received PCV20.

During record review, the Vaccine Consent Form offered residents the following vaccinations: PCV13, PPSV23, Influenza and COVID-19. PCV20 is not mentioned on this form for residents to receive.

During an interview with infection preventionist (IP) on 12/20/2023 at 9:55 a.m., the IP indicated immunizations were verified upon admission through MIIC (Minnesota Immunization Information Connection). IP stated residents and/or their families were asked and consents are obtained if immunizations are needed. IP stated IP is using the immunization hand dial for pneumococcal immunizations. IP verified R26, R31, and R40's pneumococcal immunizations as listed above. IP stated that IP was just recently made aware of the PCV20 and stated that it has not been implemented or offered by the facility. IP verified they had not been offered or provided education on PCV20. IP verified there had been no shared clinical decision making with the provider regarding pneumococcal immunizations for R26, R31 and R40.

A facility policy titled "Pneumococcal, Influenza, COVID Vaccines" with a review date of 10/23 was provided. Policy indicated: Resident/legal representative will receive and sign or provide a verbal consent for vaccines for influenza, pneumococcal and COVID vaccination on/or during the admission process or during the flu

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F 883	Continued From page 14 season. They will also receive a copy of the current vaccine information statement (VIS) related to the risks and benefits of receiving the immunization at the time of the immunization. Each resident wishing to receive the immunization will receive it as soon as possible.	F 883		

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	245589	A. BUILDING **01 - MAIN BUILDING 01** B. WING ___	**12/20/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/20/2023. At the time of this survey, Buffalo Lake Health Care Center was found not 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 and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/18/2024

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

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

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

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	245589	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	12/20/2023

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K 000	Continued From page 2 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 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 43 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test the emergency light in the Boiler Room per NFPA 101 (2012 edition), Life Safety Code, sections 7.9 and 19.2.9.1. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 12/20/2023 at 1030AM, it was revealed by observation and testing that the emergency light	K 291	It is the intent of the Buffalo Lake Healthcare Center to maintain the emergency lighting in the Boiler Room in Accordance with NFPA 101 (2012 edition) Life Safety Code, sections 7.9 and 19.2.9.1 The emergency lighting in the boiler room has been replaced by the local electrician.	1/31/24

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K 291	Continued From page 3 in the Boiler Room did not function when tested during the inspection. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291	The Maintenance Director will be responsible for testing the emergency lighting on a monthly basis. The Administrator will monitor for compliance on a quarterly basis.	

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	245589	A. BUILDING **03 - 2 ADDITION / REMODEL** B. WING ______	12/20/2023

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/20/2023. At the time of this survey, Buffalo Lake Care Center Building 03 was found NOT 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 and the 2012 edition of NFPA 99, the Health Care Facilities Code. 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 42 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101	K 355		1/31/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/18/2024

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

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUFFALO LAKE HEALTH CARE CENTER	703 WEST YELLOWSTONE TRAIL 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 355	Continued From page 1 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to document the dates of the monthy inspection on the portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 18.3.5.12 and NFPA 10. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 12/20/2023 at 1100AM, it was revealed by observation during the inspection that the date of the monthly inspection was not recorded on the inspection tag of some fire extinguishers. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	It is the intent of the Buffalo Lake Healthcare Center that portable fire extinguishers are selected, installed, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 The fire extinguishers that were identified were checked and documentation completed. The Safety Director will be responsible for documenting the dates of the monthly inspection of the portable fire extinguishers. The Administrator will monitor for compliance on a quarterly basis.	