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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: Q0TK
Facility ID: 00714

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245513**

2.STATE VENDOR OR MEDICAID NO.
(L2) **066663700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKE RIDGE CARE CENTER OF BUFFALO**
(L4) **310 LAKE BOULEVARD**
(L5) **BUFFALO, MN** (L6) **55313**

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) **02/01/2004**

6. DATE OF SURVEY 12/16/2013 (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)
01/31

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

12.Total Facility Beds **62** (L18)

13.Total Certified Beds **62** (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
	62			
(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):
PCR completed on December 16, 2013, by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal certification regulations. Please refer to the CMS 2567B. Effective 12/2/13, the facility is certified for 62 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, Unit Supervisor 12/16/2013
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 01/16/2014
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/20/2013
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5513 January 16, 2014

Mr. Jason Nelson, Administrator
Lake Ridge Care Center of Buffalo
310 Lake Boulevard
Buffalo, Minnesota 55313

Dear Mr. Nelson:

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

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

Effective December 2, 2013, the above facility is certified for:

62 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 62 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Mr. Jason Nelson, Administrator Administrator
Lake Ridge Care Center Of Buffalo
310 Lake Boulevard
Buffalo, MN 55313

RE: Project Number S5513023

Dear Mr. Nelson:

On November 13, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 24, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 16, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 6, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 24, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 2, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 24, 2013, effective December 2, 2013 and therefore remedies outlined in our letter to you dated November 13, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Brenda Fischer

Brenda Fischer, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 320-223-7338 Fax: 320-223-7348

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245513	A. Building B. Wing	12/16/2013

Name of Facility	Street Address, City, State, Zip Code
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0246 Reg. # 483.15(e)(1) LSC	Correction Completed 12/02/2013	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 12/02/2013	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 12/02/2013
ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 12/02/2013	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By 16022	Date: 1-3-14	Signature of Surveyor: 10562	Date: 12-16-13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/24/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245513	01 - MAIN BUILDING 01	12/6/2013

Name of Facility	Street Address, City, State, Zip Code
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0072	Correction Completed 11/16/2013	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By 16022	Date: 1-3-14	Signature of Surveyor: 27200	Date: 12/6/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/22/2013				

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

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

ID: Q0TK
Facility ID: 00714

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245513**

2. STATE VENDOR OR MEDICAID NO. (L2) **066663700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKE RIDGE CARE CENTER OF BUFFALO**
(L4) **310 LAKE BOULEVARD**
(L5) **BUFFALO, MN** (L6) **55313**

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) **02/01/2004**

6. DATE OF SURVEY **10/24/2013** (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) **01/31**

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

12. Total Facility Beds **62** (L18)

13. Total Certified Beds 62 (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: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	62			
(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):

At the time of the Standard survey completed on October 24, 2013, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567 along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Karlyn Pogatchnik, HFE NEII 12/09/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/18/2013 (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 **02/01/1988** (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. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7371

November 13, 2013

Mr. Jason Nelson, Administrator
Lake Ridge Care Center Of Buffalo
310 Lake Boulevard
Buffalo, Minnesota 55313

RE: Project Number S5513023

Dear Mr. Nelson:

On October 24, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 2, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 2, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter.

Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 24, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may

still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 24, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

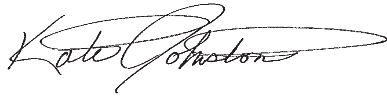
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

RECEIVED

NOV 27 2013

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

PRINTED: 11/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245513	A. BUILDING MN Dept of Health St.Cloud B. WING	10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (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 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	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly The Plan of Correction is submitted to meet requirements established by State and Federal law **F246** It is the policy of Lake Ridge Care Center that bathroom mirrors are accessible for residents that are in wheelchairs	12/2/13
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assure bathroom mirrors were accessible for resident who used wheel chairs for 3 of 3 residents, (R92, R18, and R150), who used the bathroom mirror with a wheelchair. Findings include: R92 admission Minimum Data Set (MDS) dated	F 246 12/9/13 BT	To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Bathroom mirrors will be lowered and cantered to accommodate these residents in wheelchairs. 2.Actions taken to identify other potential residents having similar occurrences: All bathroom mirrors were evaluated on November 26th for residents in wheelchairs potentially not being able to see themselves 3.Measures put in place to ensure deficient practice does not recur: All bathroom mirrors in the facility will be lowered 2-5", and will be cantered towards the resident to insure that they are able to see themselves in the mirror. 4.Effective implementation of actions will be monitored by: After mirrors are installed, we will audit	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	27 NOV 13

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

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
	245513	A. BUILDING ______ B. WING ______	10/24/2013

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F 246	Continued From page 1 10/8/13, identified the resident had no cognitive impairment and required oversight assistance from one staff in personal hygiene. During interview on 10/21/13, at 5:37 p.m. R92 stated when he was first admitted to the facility he was in a wheelchair and was not able to see himself in the mirror in the bathroom. He stated he complained to several nurses about this but was told, "That's just the way it is." During observation on 10/21/13, at 5:37 p.m. R92's bathroom mirror was approximately 5 feet from the floor with a shelf and sink below the mirror. The mirror was flat against the wall with no tilt. R18 Admission MDS dated 8/30/13, identified the resident had no cognitive impairment and needed extensive assistance from one person for personal hygiene. During interview on 10/24/13, at 10:45 a.m. R18 stated when she is in a wheelchair she is not able to see in the bathroom mirror. She stated she has to sit on her bed with a hand held mirror to fix her hair and put on her make up. R18 stated she would rather get ready in the bathroom, but is unable to stand in front of the mirror to see herself. R18 stated her roommate had a full length mirror on her side of the room, but R18 does not have one of those. R18 stated, "Even that [full length mirror] would make it a little easier."	F 246	20 residents in wheelchairs to ensure they can see themselves properly. This report will be submitted to the QAPI committee to insure the installation was appropriate 5.Those responsible to maintain compliance will be: The Environmental Director will insure that all mirrors are installed and cantered. Completion date for certification purposes only is: December 2, 2013	

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F 246	Continued From page 2 During observation on 10/24/13, at 10:45 a m R18's bathroom mirror was approximately 5 feet from the floor with a shelf and sink below the mirror The mirror was flat against the wall with no tilt. R150 was a recent new admission to the facility During interview on 10/24/13, at 10:20 a m R150 sated she is not able to see in the bathroom mirror while sitting in the wheelchair She stated she has to stand up if she wants to see in the mirror, and that can "be inconvenient " During observation on 10/24/13, at 10:20 a m. R150's bathroom mirror was approximately 5 feet from the floor with a shelf and sink below the mirror The mirror was flat against the wall with no tilt During interview on 10/24/13, at 9:56 a m maintenance (M)-A stated the nurses have told him the residents have been complaining about not being able to see in the bathroom mirror when they are in the wheelchairs. He stated he was aware it was a problem and had been "thinking" about tiltable mirrors for the resident rooms However, there was no plan currently in place During interview on 10/24/13 at 10:30 a m nursing assistant (NA)-A stated she was aware there are residents who are unable to use their bathroom mirror while in the wheelchair because it is too high NA-A stated those resident either use a hand held mirror or have a full length mirror	F 246		

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F 246	Continued From page 3 out in their room to use. During interview on 10/24/13, at 10:35 a.m registered nurse (RN)-B stated residents had complained to her about not being able to see in their bathroom mirrors while in a wheelchair. RN-B stated most of the concern comes from the residents who are in the facility for a rehabilitation stay because they are trying to become as independent as possible. RN-B stated she had talked to M-A about the concern in the past.	F 246		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	F279 It is the policy of Lake Ridge Care Center to ensure the care plan includes target behaviors and non pharmacological interventions to be in place for the use of a PRN anxiety medication. To assure continued compliance, the following plan has been put into place; 1.Regarding cited residents: The identified resident had already been discharged from the facility at the time of the survey exit. 2.Actions taken to identify other potential residents having similar occurrences: Residents on psychotropic medications will be audited to correct any current care plans that may be lacking target behaviors and non-pharmacologic interventions for psychotropic medications. 3.Measures put in place to ensure deficient practice does not recur:	12/2/13

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F 279 — Continued From page 4

by:
Based on interview and document review, the facility failed to ensure the care plan included target behaviors and non pharmacological interventions in place for the use of a PRN (as needed) anti anxiety medication for 1 of 3 residents, (R95) who received anxiety medications

Findings include:

R95 admission Minimum data set (MDS) dated 9/5/13, identified no cognitive impairments or behaviors, but received an antianxiety medication daily.

R95's physician orders dated 10/23/13, identified R95 was on antianxiety medication of PRN Klonopin 1 milligram (mg) once a day; midday for panic disorder and Klonopin 1 mg PRN at HS (hour of sleep) for panic disorders which started on 9/20/13.

Review of a Psychologist note written on 9/21/13, regarding R95 indicated the following: R95 "Said she has high anxiety about everything but believes she manages the anxiety well. She said she has panic attacks [R95] said she tries to distract herself when she panics She said she knows how to take slow, deep breaths and relax her body when she panics. ." The Summary and treatment plan recommendations were "[R95] said she has high anxiety and panic attacks. She said she distracts herself when she gets anxious or panics. [R95] agreed to take slow, deep

F 279 — All nursing staff that contributes to care planning will be trained to use the new Psychotropic Drug Checklist. This will be used for any new resident with psychotropic medication or new order of psychotropic medication for a current resident, it will also be used to do an audit and correct any current care plans that may be lacking target behaviors and non-pharmacologic interventions for psychotropic medications This new form has specific items to check off that refers to adding target behaviors and non-pharmacologic approaches to the care plan

4.Effective implementation of actions will be monitored by:
Audits will be done monthly for 6 months and then quarterly. This audit information will be reported to the QAPI committee for compliance review for four (4) quarters

5.Those responsible to maintain compliance will be:
The Director of Nursing will be responsible for on-going compliance.

Completion date for certification purposes only is: December 2, 2013

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F 279	Continued From page 5 breaths and relax her body when she experiences anxiety " R95's care plan updated 10/14/13, instructed staff, "Potential for side effects of Psychotropic medication: Receives Klonopin for the diagnoses of anxiety medication as ordered Update MD (physician) if behaviors increase Monthly review by pharmacist consultant Social service follow up as needed, 1:1 support as needed " The care plan did not address non pharmacological interventions, nor did it address the specific behaviors which the resident required the use of Klonopin The care plan did not include the information identified by the psychologist of taking slow, deep breaths and relaxing her body which has been successful for R95 when she experiences "anxiety " During interview on 10/24/13, at 12:30 p m. Social worker (SW)-A stated she was not involved in R95's care, treatment of anxiety, or aware of any specific interventions to be used for non pharmacological treatment of R95's anxiety During interview on 10/24/13, at 10:15 a m Registered nurse (RN)-A verified R95's current plan of care did not have specific behaviors related to anxiety nor was there non pharmacological interventions which could be attempted The facility policy titled Psychotropic Drug Monitoring dated November 2012 indicated "Residents with untoward behaviors will have a	F 279		

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F 279	Continued From page 6 target behavior identified Target behaviors must be 'specific' in identification The term agitation is too vague, 'walking rapidly' is specific Interventions must be documented in the plan of care "	F 279		
F 329 SS=D	483 25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 residents	F 329	**F329** It is the policy of Lake Ridge Care Center that parameters are in place for the use and non-pharmacological interventions of antianxiety medications To assure continued compliance, the following plan has been put into place; 1.Regarding cited residents: The identified resident had already been discharged from the facility at the time of the survey exit. 2.Actions taken to identify other potential residents having similar occurrences: Residents on psychotropic medications will be audited to ensure that all current residents have target behaviors identified with the use of PRN antianxiety medication and specific parameters for the use of PRN medications given for behaviors or anxiety. 3.Measures put in place to ensure deficient practice does not recur: All licensed nursing staff will be trained to use the new Psychotropic Drug Checklist form for all psychotropic medication orders initiated and for any newly admitted residents to the facility who	12/2/13

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F 329	Continued From page 7 (R95) who received antianxiety medication, had parameters for use and non-pharmacological interventions placed to aid with anxiety Findings include: R95's admission minimum data set (MDS) dated 9/3/13, identified no cognitive impairments or behavior problems, but received antianxiety medication daily During observation on 10/21/13, at 5:57 p.m R95 was observed sitting in her room watching television, calmly R95's physician orders dated 10/23/13, included an antianxiety medication of PRN (as needed) Klonopin 1 mg (milligram) once a day; midday for panic disorder, and Klonopin 1 mg PRN at HS (hour of sleep) for panic disorder, which started 9/20/13 A Psychotropic Drug Review dated 9/24/13, identified R95 was currently taking "Klonopin 1 mg every day and PRN x 1" with a reason of "panic disorder " The target symptoms for the Klonopin was listed as "increased anxiety noted due to not being able to go home, impulsive behaviors related to self transferring, and not keeping brace on knee noted." The non-pharmacological approach's used for these behaviors have been 1:1 with social services, family visits and phone calls; seem effective for short periods of time." Review of a Psychologist note written on 9/21/13, regarding R95 indicated the following: R95 "Said she has high anxiety about everything but believes she manages the anxiety well. She said	F 329	takes psychotropic medication The checklist includes the addition of specific parameters for PRN medication use and the addition of non-pharmacologic interventions. The monthly Psychotropic Drug Review also includes a review of specific target behaviors or symptoms for each medication An audit will be done to correct any current orders in the facility that does not have parameters in place for the use and non-pharmacological interventions of antianxiety medications <u>4.Effective implementation of actions will be monitored by:</u> Audits will be done monthly for 6 months and then quarterly. This audit information will be reported to the QAPI committee for compliance review for four (4) quarters. <u>5.Those responsible to maintain compliance will be:</u> The Director of Nursing will be responsible for on-going compliance. <u>Completion date for certification purposes only is:</u> December 2, 2013	

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F 329	Continued From page 8 she has panic attacks [R95] said she tries to distract herself when she panics She said she knows how to take slow, deep breaths and relax her body when she panics. " The Summary and treatment plan recommendations were "[R95] said she has high anxiety and panic attacks She said she distracts herself when she gets anxious or panics [R95] agreed to take slow, deep breaths and relax her body when she experiences anxiety " R95's care plan dated 10/14/13, included, "Potential for side effects of psychotropic medication: Receives Klonopin for the diagnoses of anxiety medication as ordered Update MD (physician) if behaviors increase Monthly review by pharmacist consultant Social service follow up as needed, 1:1 (one on one) support as needed " The care plan did not identify what non-pharmacological interventions could be used to assist R95 with her anxiety, or what behaviors R95 had that would require the use of Klonopin The psychologist's recommendations of 9/21/13 had not been added to the care plan R95's Medication Administration Record from September 20, 2013, through October 22, 2013 showed R95 had received the PRN Klonopin 31 times The reason for the administration was listed as, "increased anxiety," "unable to sleep," "anxiety related to room change," "anxiety related to therapy," "anxiety," anxiety related to knee pain," "anxiety related to pain," or "anxiety related to cat " No specific behavior was identified for the use of Klonopin during this time, and no	F 329		

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F 329	Continued From page 9 non-pharmacological interventions had been identified as being tried prior to administration of this anti-anxiety medication. During interview on 10/24/13, at 12:30 p.m. Social worker (SW)-A stated she was not involved in R95's care, treatment of anxiety, or aware of any specific non-pharmacological treatment of R95's anxiety. During interview on 10/24/13 at 10:15 a.m. Registered nurse (RN)-A stated R95 did not have and specific behaviors related to anxiety the facility was monitoring. RN-A verified there was no non-pharmacological interventions identified nor was there specific parameters when R95 was to receive PRN Klonopin. RN-A stated the nurses just give R95 PRN Klonopin when she requests it for "anxiety." The facility policy titled Psychotropic Drug Monitoring dated November 2012, indicated, "Residents with untoward behaviors will have a target behavior identified. Target behaviors must be 'specific' in identification. The term agitation is too vague, 'walking rapidly' is specific. Interventions must be documented in the plan of care. 'Will listen to music when starts to walk rapidly in the hall.'"	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**F371** It is the policy of Lake Ridge Care Center to monitor and maintain safe dish washing temperatures, store food under sanitary conditions and follow equipment sanitation procedures to promote sanitation and food safety.	12/2/13

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F 371	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor and maintain safe dishwashing temperatures, failed to store food under sanitary conditions, and follow equipment sanitation procedures to prevent the potential spread of food borne illness and promote sanitation and food safety. This had the potential to affect 58 of 58 residents in the facility who received food/fluids out of the facility kitchen. Findings include: During kitchen tour on 10/21/13, at 1:25 p.m. cook (C-A) stated they used a high temperature, one compartment dish machine. The October dishwashing temperature log was reviewed. Multiple dishwashing temperatures were below 150 degrees Fahrenheit (F) for the wash cycle and below 180 degrees F for the rinse cycle along with numerous missing temperatures. C-A stated "the booster doesn't work right, we have asked them to fix it, it's a maintenance issue." C-A further stated "I don't know why so many temperatures were missing, the dietary director (DD) takes care of that." During observation on 10/21/13, at 1:45 p.m. dietary aide (DA-A) ran five loads of dishes through the dishwasher. The digital temperature	F 371	following plan has been put into place; 1.Regarding cited residents: No specific residents were affected by this deficiency, although there was the potential to affect 58 residents. -Dish washing temperatures are recorded daily and are reviewed for safe dish washing temperatures -Food is monitored to insure it is stored under sanitary conditions -Equipment sanitation procedures have been implemented to promote sanitation and food safety 2.Actions taken to identify other potential residents having similar occurrences: -Dish washing temperatures are recorded daily and are reviewed for safe dish washing temperatures. -Food is monitored to insure it is stored under sanitary conditions. -Equipment sanitation procedures have been implemented to promote sanitation and food safety, and freezer has been defrosted 3.Measures put in place to ensure deficient practice does not recur: -Dietary employees will be re-trained on the proper use of the dish washing machine, including temperature monitoring, logging and reporting procedures beginning November 27-December 4. Old forms have been redone, and have been updated with the minimum temperature requirements and reporting procedure -Dietary employees will be re-trained on the proper storage, labeling and dating of food products under sanitary conditions	

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F 371	Continued From page 11	F 371		

gauge on the outside of the dishwasher read:
#1 141F wash, 145F rinse
#2 141F wash, 154F rinse
#3 143F wash, 163F rinse
#4 145F wash, 166F rinse
#5 147F wash, 169F rinse

During interview on 10/21/13, at 1:46 p.m. DA-A stated she records the temperatures from the gauge on the dishwasher "but I have not done it yet today." DA-A further stated, "I was not here yesterday when low temperatures were recorded, I would tell my supervisor or contact maintenance if the temperatures were low and redo the rack of dishes until it was up to temp."

During interview on 10/21/13, at 2:10 p.m. the maintenance director (MD) stated he was not aware of any issues with low temperatures for the dishmachine. MD stated a new booster was put in February, 2013.

During interview on 10/21/13, at 3:05 p.m. the registered dietitian (RD) stated "I was not aware there were any issues with the dishwasher, the dietary director takes care of that," further stating "we will use disposable dishes tonight and rewash all dishes after it is fixed."

During interview on 10/21/13, at 5:05 p.m. the Hobart service technician (HST) stated he had been out to fix various issues with the dishmachine in February and March of 2013, and that the temperature on the digital gauge on the dishmachine should be at least 150 degrees F for

-The freezer was immediately defrosted, and has been placed on a quarterly defrost cycle on the Dietary cleaning list

<u>4.Effective implementation of actions will be monitored by:</u>
- Dietary manager will review dish washing temperatures weekly. This weekly temperature review will be reported to the QAPI committee quarterly for compliance purposes.
-The Dietary manager, or a designated Dietary employee, will spot check storage, dating and labeling randomly one time per week. These spot checks will be reported to the QAPI for compliance review for two quarters, or until compliance is met.
-The freezer will be defrosted on a scheduled, quarterly basis.

<u>5.Those responsible to maintain compliance will be:</u>
-The Dietary manager will insure the dish washing temperature log is filled out correctly and will report those temperatures, and potential remedies, to the QAPI on a quarterly basis.
-The Dietary manager, or their designee, will insure food is stored, labeled and dated under sanitary conditions
-The Dietary manager will report the completion of the freezer defrosting to the QAPI for two quarters.

<u>Completion date for certification purposes only is:</u> December 2, 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245513	A. BUILDING ______ B. WING ______	10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO	310 LAKE BOULEVARD BUFFALO, MN 55313

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 12	F 371		

wash and 180 degrees for rinse Four wash/rinse cycles were observed:
#1 154F wash, 172F rinse
#2 153F wash 190F rinse
#3 154F wash, 185F rinse
#4 153F wash, 168F rinse
HST stated in a follow up email dated 10/21/13, at 7:48 p m , "the result of the booster heater not actually heating is lower final rinse temperatures and lower washtank temperatures as well "

During interview at 5:27 p m on 10/21/13, the administrator (A) stated there had been only one work order request for the dishmachine to be fixed on 7/12/13, further stating "I was not aware of any issues with the dishmachine "

Review of the Dish Wash & Rinse Temperature flow sheets from May 2013 - October 2013 identified the dishwasher wash/rinse temperatures were checked three times each day The wash temperatures were either missing or below 150 degrees F in October, 58 of 61 opportunities; in September, 80 of 90 opportunities; in August 85 of 93 opportunities; in July 56 of 93 opportunities; in June 44 of 90 opportunities; in May 46 of 93 opportunities The rinse temperatures were missing or below 180 degrees F in October, 47 of 61 opportunities; in September 67 of 90 opportunities; in August 74 of 93 opportunities; in July 49 of 93 opportunities; in June 42 of 90 opportunities and in May 45 of 93 opportunities

Review of a service order request on 3/8/13 indicated a "heating problem" on the dishmachine

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F 371	Continued From page 13 was identified and corrected Review of a posted sign, by the dish machine, dated 3/14/13, and signed by the DD indicated "If the water temperature on the dish machine is too low: rinse needs to be at 185 degrees - wash at 145 degrees or more, Use the pencil and hit the reset button on the booster " Review of the facilities infection control logs from November 2012 through October 2013 contained no identifiable gastrointestinal illness outbreak in the facility During an interview on 10/21/13, at 10:37 a m the DD stated staff should tell her when the temperatures are not correct. "I would contact maintenance and/or Hobart if necessary " DD further stated "I did not monitor the recording of the temperatures" and verified this had been an issue for "awhile " A facility policy entitled Dishwashing Machine Use dated November 2010, under Policy interpretation and implementation included, "the operator will check temperatures using the machine gauge with each dishwashing machine cycle and will record the results in a facility approved log, the supervisor will check the calibration of the gauge weekly and if hot water temperatures do not meet requirements, cease use of the dishwashing machine immediately "	F 371		

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F 371	Continued From page 14 The facility failed to store food under sanitary conditions and follow equipment sanitation procedures to prevent the potential spread of food borne illness The following concerns were observed during the initial kitchen tour on 10/21/13, at 1:15 p m with C-A: In the reach in freezer, frozen foods were observed to by lying on the bottom of the freezer, in paper or plastic bags that were ripped, unsealed, not labeled to identify contents, no manufacturer used by dates were present and no dates open were present The following items were noted: A 5 pound (lb) plastic bag of chicken nuggets had been opened the top of the bag was not sealed, not dated with an opened or used by date nor stored in a sealed food-grade plastic bag to prevent the possibility of food borne illness A 5 lb plastic bag of chicken strips had been opened, the top of the bag was not sealed, not dated with an opened or used by date nor stored in a sealed food-grade plastic bag to prevent the possibility of food borne illness A 5 lb plastic bag of chicken breasts had been opened, the top of the bag was not sealed, not dated with an opened or used by date nor stored in a sealed food-grade plastic bag to prevent the possibility of food borne illness	F 371		

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F 371	Continued From page 15 A 5 lb brown paper bag of sweet potato french fries had been opened, the top of the bag was not sealed, not dated with an opened or used by date nor stored in a sealed food-grade plastic bag to prevent the possibility of food borne illness Two 5 lb brown paper bags of seasoned potato wedges had been opened 1 bag had open cuts in the bag exposing the wedges and the other had a hole in the bottom of the bag Both bags were not sealed, not dated with an opened or used by date nor stored in a sealed food-grade plastic bag to prevent the possibility of food borne illness A 3 lb plastic bag of chicken tenderloins had been opened, the top of the bag was not sealed, not dated with an opened or used by date nor stored in a sealed food-grade plastic bag to prevent the possibility of food borne illness Twelve individual portions of vanilla ice cream were on a tray with loosely fitting plastic wrap over them They were not dated with an opened or used by date nor stored in a sealed food-grade plastic bag to prevent the possibility of food borne illness C-A verified the packages were not stored properly, "they know to date the package when it is opened, it should have been done " The Meals on Wheels Freezer which contained individual portions for the restaurant style food	F 371		

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	245513	A. BUILDING ______ B. WING ______	10/24/2013

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F 371	Continued From page 16 service was observed to have a heavy buildup of frost and ice on the four internal shelves and top freezer coil C-A stated the freezer was not on any cleaning list "We just do it, further stating "I've seen it worse " During the follow-up kitchen tour on 10/23/13, at 10:37 a m DM verified the freezer had heavy frost buildup and needed to be defrosted DM stated the freezer was not on a maintenance or cleaning schedule "but it will be "	F 371		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245513	A BUILDING 01 - MAIN BUILDING 01 B WING	10/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS 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 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Lake Ridge Care Center of Buffalo was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145	K 000	POC ok TS 11-29-13 RECEIVED NOV 27 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 10/24/13 Dc: 12-2-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 27 Nov 13

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 ST. PAUL, MN 55101-5145, or By e-mail to: Barbara lundberg@state mn us and Marian.Whitney@state mn us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1 A description of what has been, or will be, done to correct the deficiency 2. The actual, or proposed, completion date. 3 The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Lake Ridge Care Center is a 2-story building with no basement The building was constructed at 2 different times The original building was constructed in 1960 and was determined to be of Type II(111) construction. In 1976, an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is automatic sprinkler protected throughout The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 62 beds and had a census of 58	K 000		

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K 000	Continued From page 2 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits 7.1.10 This STANDARD is not met as evidenced by: Based on observations, it was determined that the facility failed to provide exit discharges that were readily accessible (free and unobstructed) at all times in accordance with NFPA 101-2000 edition, Sections 19.2.7, 7.1, 7.1.10 and 7.5.4. This was due to the lack of a hard path to a public way at 1 of 7 exits This deficient practice could affect all patients, staff and visitors if emergency evacuation via this discharge was necessary. Findings include: On facility tour between 12:30 PM to 3:30 PM on 10/22/2013, it was observed that the temporary exit discharge from the northwest wing was not provided with a hard surfaced path the leads to a public way The temporary exit discharge located at the northwest exit has a plywood ramp that leads into a construction/demolition and refuse area that is neither level nor has a continuous	K 072	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly The Plan of Correction is submitted to meet requirements established by State and Federal law. **K072** It is the policy of Lake Ridge Care Center to provide exit discharges that are free and unobstructed at all times The temporary hard path for our construction project terminated into a rocky substrate. A hard path has been added onto the existing temporary hard path, including a set of steps, which leads to a concrete path that leads to our back parking lot, the public way. The Environmental Director is responsible for monitoring the hard path to make sure it remains free and unobstructed at all times. <u>Completion date for certification purposes only is:</u> November 16, 2013	11/26/13

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K 072	Continued From page 3 compliant hard surfaced path that leads to the public way It was also noted that the current plywood temporary ramp has areas on each side of the ramp that consists of loose sand, gravel and dirt and it also has multiple drops to the sides that are greater than 7 inches when measured from the top of the ramp to the bottom of the drop These deficient practices were confirmed by the Maintenance Director (BT)	K 072		