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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: U4UK

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

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

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

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

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

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

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

6. DATE OF SURVEY **10/14/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Holly Kranz, HFE NE II — 10/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 10/27/2014 (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
11/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS
Posted 10/30/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/13/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245589

October 27, 2014

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

Dear Mr. Rust:

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 September 30, 2014 the above facility is certified for or recommended for:

49 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any 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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 27, 2014

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

RE: Project Number S5589023

Dear Mr. Rust:

On September 9, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 21, 2014 . This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On October 14, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 19, 2014 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 August 21, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 30, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 21, 2014, effective September 30, 2014 and therefore remedies outlined in our letter to you dated September 9, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245589	A. Building B. Wing	10/14/2014

Name of Facility	Street Address, City, State, Zip Code
BUFFALO LAKE HEALTH CARE CTR	703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **09/30/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **09/30/2014**	ID Prefix **F0258** Reg. # **483.15(h)(7)** LSC	Correction Completed **09/30/2014**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **09/30/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/30/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	10/27/2014	33561	10/14/2014
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
8/21/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245589	A. Building / B. Wing: 02 - 2012 BUILDING ADDITION	9/19/2014

Name of Facility	Street Address, City, State, Zip Code
BUFFALO LAKE HEALTH CARE CTR	703 WEST YELLOWSTONE TRAIL, PO 368 BUFFALO LAKE, MN 55314

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	08/25/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KJ	10/27/2014	22373	9/19/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/21/2014			Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: U4UK
Facility ID: 00550

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) 245589
2. STATE VENDOR OR MEDICAID NO.
(L2) 090243800

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

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

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

6. DATE OF SURVEY 08/21/2014 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12. Total Facility Beds 49 (L18)

13. Total Certified Beds 49 (L17)

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

And/Or Approved Waivers Of The Following Requirements:
___2. Technical Personnel
___3. 24 Hour RN
___4. 7-Day RN (Rural SNF)
___5. Life Safety Code
__6. Scope of Services Limit
__7. Medical Director
__8. Patient Room Size
__9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Pat Gegen, HFE NE II 09/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 10/13/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0549

September 9, 2014

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

RE: Project Number S5589023

Dear Mr. Rust:

On August 21, 2014, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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;

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
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 September 30, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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 November 21, 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 February 21, 2015 (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 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		9/30/14

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

Electronically Signed | 09/16/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report injuries of unknown origin to the administrator, state agency (SA) and failed to thoroughly investigate 7 of 12 residents (R10, R15, R23, R33, R38, R42, and R45) allegations reviewed. Findings include: R10's quarterly Minimum Data Set (MDS), dated 6/17/14, indicated R10 had severe cognitive impairment, exhibited behavioral symptoms not directed towards others daily, and took an anticoagulant medication (taken to prevent clotting) daily during the review period. R10's Progress Note, dated 7/27/14, indicated R10 was found to have a dark purple bruise on his side when being turned. The note further indicated the bruise to be 23 cm (centimeters) X	F 225	Preparation and execution of the response of the plan does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State Law require it. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility□s allegation of compliance in accordance with section 7305 of the State Operations Manual. F225 It is the intent of the Buffalo Lake Healthcare Center to develop and implement written policies and procedures	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 (by) 23 cm in size, was hard to touch and edematous (swollen). R10's physician had been faxed a note on 7/27/14 about the discovery of the bruise, which described the location as "left rear iliac crest. Measures 23 cm x 23 cm. Dark purple and yellow in color. Area is swollen and hard to the touch does complain of soreness when palpated. Resident did have a recent fall 7/22/14." An incident report provided by the facility, dated 7/27/14, indicated R10 had a 23 cm X 23 cm bruise on his left side. The report indicated R10 was unable to give a description for how he had obtained the bruise, and he had been hospitalized from 7/19/14 through 7/21/14. Further, the report indicated R10 did have a fall on 7/22/14, had elevated Coumadin (an anticoagulant medication) levels last week, and it was not considered to be a reportable issue. The report did not contain any investigation regarding how R10 may have obtained the bruising, nor was the administrator or state agency immediately notified of the incident. R15's quarterly MDS, dated 7/15/14, indicated R15 was cognitively intact, demonstrated no behavioral symptoms, and took an anticoagulant medication daily during the review period. R15's Progress note, dated 5/23/14, indicated R15 was found to have a 2.5 cm X 6 cm bruise on his left hip during a bath. The note indicated staff and R15 were unsure of how it may have occurred. An incident report provided by the facility, dated	F 225	that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property and report any injuries of unknown origin to the administrator and state agency immediately. R10 has been interviewed and chart reviewed to indicate bruising is consistent with fall from earlier in the week. R15 has since discharged from the facility. R23 has been interviewed and denied any wrong doing, states "I bruise so easy". R33 has since discharged from the facility. For R38, R42 and R45 the facility will investigate alleged violation of abuse/mistreatment and if verified reporte the results and corrective action taken to the appropriate state agency. This practice has the potential to affect all residents. Facility staff will be educated to report any incident of potential abuse/mistreatment. Licensed staff will be educated regarding the requirement to initiate an incident report when an incident of potential abuse/mistreatment occurs and report alleged violations of abuse/mistreatment immediately to the administrator and state agency. Audits will be completed on all incidents of unknown origin by the Director of Nursing/designee, Social Services and Administrator to ensure initiation of reports to the state agency as appropriate. Any required follow up will be completed at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 5/23/14, indicated R15 had a bruise on his left hip. The report further indicated R15 and staff were unsure of how it happened, and this report was not filed as the bruise was not in a suspicious location or of suspicious nature. The report did not indicate any investigation regarding how R15 obtained the bruise. Also, there was no indication the administrator or state agency was immediately notified of the incident. A subsequent note, dated 7/23/14, indicated R15 was found to have a 7.4 cm X 12 cm bruise when staff were completing morning cares. The note indicated R15 was not sure how it occurred and denied pain. The note did not provide any investigation regarding how R15 obtained the bruise. A separate incident report provided by the facility, dated 7/23/14, indicated staff noted another large bruise located on R15's upper left arm with morning cares. The report further indicated staff and R15 were unaware how the bruise occurred, as the skin concern were not of suspicious nature or location. The report did not indicate any investigation regarding how R15 obtained the bruise. Also, there was no indication the administrator or state agency was immediately notified of the incident. R23's quarterly MDS, dated 7/18/14, indicated R23 was cognitively intact, demonstrated no behavioral symptoms, and took an anticoagulant medication 5 of 7 days during the review period. R23's Progress Note, dated 8/6/14, indicated R23 was noted to have a bruise on the right forearm measuring 15 cm X 10 cm. The note stated R23	F 225	Audit results will be reviewed presented at QAA for review. Corrective action will be completed by 9/30/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4 was uncertain how she obtained the bruise. An incident report provided by the facility, dated 8/5/14, indicated R23 was noted to have a bruise on the right forearm measuring 15 cm X 10 cm in size. The report indicated they were uncertain what happened that caused the bruise, the area was not in a suspicious location, and had an extensive history of bruising related to Coumadin use. The report did not identify investigation regarding how R23 obtained the bruise. There was no indication the administrator or state agency was immediately notified of the incident. R33's significant change in condition MDS, dated 6/18/14, indicated R33 had severe cognitive impairment, exhibited no behavioral symptoms, and did not take an anticoagulant medication. R33's Progress Note, dated 6/24/14, indicated R33 was noted to have a 5 cm X 2.8 cm bruise on his left forearm. An incident report provided by the facility, dated 6/23/14, indicated R33 had a bruise on the left forearm measuring 5 cm X 2.8 cm. The report further indicated, "Will not file a VA as not in a suscepious [sic] area." The report did not indicate any investigation regarding how R33 obtained the bruise. There was no indication the administrator or state agency was immediately notified of the incident. R38's quarterly MDS, dated 7/1/14, indicated R38 was cognitively intact, demonstrated no behavioral symptoms, and did not take an anticoagulant medication. R38's Progress Note, dated 7/27/14, indicated	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 5 R38 to have a 3.5 cm X 0.2 cm skin tear/scratch with 6.5 cm X 3 cm of bruising surrounding it on his right forearm that was found by staff when doing morning cares. The note indicated staff was unsure of how it happened and the resident stated it happened last night, but was unable to provide details. An incident report provided by the facility, dated 7/27/14, indicated R38 was found to have a skin tear/scratch with bruising noted on his right forearm. The report stated resident stated it occurred last night, but was unable to identify specifics about how or when it occurred. Further, the report indicated the area was not in a suspicious location, and was not a reportable incident. The report did not identify any investigation regarding how R38 obtained the bruise. The note did not indicate any investigation regarding how R38 obtained the bruise, nor was the administrator and state agency immediately notified of the incident. R42's quarterly MDS, dated 5/20/14, indicated R42 had severe cognitive impairment, exhibited no behavioral symptoms, and did not take an anticoagulant medication. R42's Progress Note, dated 8/10/14, indicated R42 was found to have a large bruise on his right hip when being given a bath. Further, the note indicated the bruise to measure 15 cm X 16 cm, and R42 denied pain. The note did not provide any investigation regarding how R42 obtained the bruise. An incident report provided by the facility, dated	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 6 8/10/14, indicated R42 was noted to have a bruise measuring 15 cm X 16 cm discovered during his bath that evening. The report indicated R42 was unable to give a description for how he had obtained the bruise, was unsteady on his feet and the bruise was not in a suspicious location, so a report was not filed. The report did not contain any investigation regarding how R42 may have obtained the bruising nor was the administrator and state agency immediately notified of the incident. R45's quarterly MDS, dated 6/27/14, indicated R45 had severely impaired cognitive skills, demonstrated no behavioral symptoms, and did not take an anticoagulant medication. R45's Progress Note, dated 7/16/14, indicated R45 had a 5 cm X 3 cm bruise on the top of her head that was found during her bath. The note further indicated staff nor R45 were sure how it may have occurred. The note did not indicate any investigation on how R45 obtained the bruise. An incident report provided by the facility, dated 7/16/14, indicated R45 was reported to have a "...large dark purple bruise", on her head. The report further indicated R45 was unable to give a description of what may have caused the bruise, but was not considered reportable because the area was not in a suspicious location, or of a suspicious size or shape. The report did not indicate any investigation on how R45 obtained the bruise, nor was the administrator and state agency immediately notified of the incident. During interview on 8/20/14 at 11:50 a.m., the	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 7	F 225		

director of nursing (DON) stated an injury or bruise would have to be suspicious in size, nature, or location for the facility to report as a concern. The DON further stated the nurse completing the incident report should document the reason why they felt if was not a reportable incident.

When interviewed on 8/21/14 at 10:39 a.m., licensed social worker (LSW)-A stated herself and the DON are responsible for completing the abuse reviews when concerns are raised or incidents reported. LSW-A stated completing an investigation on each incident is important to rule out if abuse is occurring. LSW-A stated the incidents for R10, R15, R23, R33, R38, R42, and R45 should have been reported to the administrator and SA immediately and then investigated.

During a subsequent interview on 8/21/14 at 10:51 a.m., the DON stated the staff should investigate in order to look beyond the potential for just sexual abuse, but for physical abuse as well. The DON further stated there was not enough evidence to prove the incidents for R10, R15, R23, R33, R42, and R45 weren't abuse and should have been reported to the SA.

A facility Vulnerable Adult Policy, dated 10/22/13, indicated, "The Buffalo Lake Healthcare Center (BLHCC) will comply with Minnesota Vulnerable Adult Act and section 1150B of the Social Security Act regarding the reporting and investigating the maltreatment of Vulnerable Adults in this facility." Further, the policy indicated incidents of abuse or neglect need to be reported immediately to the administrator and SA.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 8	F 226		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to ensure the facility implemented their policy for allegations of abuse, neglect and injuries of unknown origin were immediately reported to the administrator, state agency and thoroughly investigated for 7 of 12 resident (R10, R15, R23, R33, R38, R42, and R45) allegations reviewed. Findings include: A facility Vulnerable Adult Policy, dated 10/22/13, indicated, "The Buffalo Lake Healthcare Center (BLHCC) will comply with Minnesota Vulnerable Adult Act and section 1150B of the Social Security Act regarding the reporting and investigating the maltreatment of Vulnerable Adults in this facility." Further, the policy indicated incidents of abuse or neglect need to be reported immediately to the administrator and SA, with immediately being defined as, "Immediately is immediately, provide safety first if able." R10's quarterly Minimum Data Set (MDS), dated 6/17/14, indicated R10 had severe cognitive impairment, exhibited behavioral symptoms not directed towards others daily, and took an	F 226	F 226 It is the intent of the Buffalo Lake Healthcare Center to develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property and report any injuries of unknown origin to the administrator and state agency immediately. R10 has been interviewed and chart reviewed to indicate bruising is consistent with fall from earlier in the week. R15 has since discharged from the facility. R23 has been interviewed and denied any wrong doing, states I bruise so easy. R33 has since discharged from the facility. R38, R42 and R45 the facility will investigate alleged violation of abuse/mistreatment and if verified reported the results and corrective action taken to the appropriate state agency. This practice has the potential to affect all residents. The facility vulnerable adult policy was reviewed and found to be current. Facility staff will be educated to report any	9/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 9 anticoagulant medication (taken to prevent clotting) daily during the review period. R10's Progress Note, dated 7/27/14, indicated R10 was found to have a dark purple bruise on his side when being turned. The note further indicated the bruise to be 23 cm (centimeters) X (by) 23 cm in size, was hard to touch and edematous (swollen). R10's physician had been faxed a note on 7/27/14 about the discovery of the bruise, which described the location as "left rear iliac crest. Measures 23 cm x 23 cm. Dark purple and yellow in color. Area is swollen and hard to the touch does complain of soreness when palpated. Resident did have a recent fall 7/22/14." An incident report provided by the facility, dated 7/27/14, indicated R10 had a 23 cm X 23 cm bruise on his left side. The report indicated R10 was unable to give a description for how he had obtained the bruise, and he had been hospitalized from 7/19/14 through 7/21/14. Further, the report indicated R10 did have a fall on 7/22/14, had elevated Coumadin (an anticoagulant medication) levels last week, and it was not considered to be a reportable issue. The report did not contain any investigation regarding how R10 may have obtained the bruising, nor was the administrator or state agency immediately notified of the incident as identified by the facility policy. R15's quarterly MDS, dated 7/15/14, indicated R15 was cognitively intact, demonstrated no behavioral symptoms, and took an anticoagulant medication daily during the review period.	F 226	incident of potential abuse/mistreatment. Licensed staff will be educated regarding the requirement to initiate an incident report when an incident of potential abuse/mistreatment occurs and report alleged violations of abuse/mistreatment immediately to the administrator and state agency. Audits will be completed on all incidents of unknown origin by the Director of Nursing/designee, Social Services and Administrator to ensure initiation of reports to the state agency as appropriate. Any required follow up will be completed at that time. Audit results will be reviewed presented at QAA for review. Corrective action will be completed by 9/30/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 10 R15's Progress note, dated 5/23/14, indicated R15 was found to have a 2.5 cm X 6 cm bruise on his left hip during a bath. The note indicated staff and R15 were unsure of how it may have occurred. An incident report provided by the facility, dated 5/23/14, indicated R15 had a bruise on his left hip. The report further indicated R15 and staff were unsure of how it happened, and this report was not filed as the bruise was not in a suspicious location or of suspicious nature. The report did not indicate any investigation regarding how R15 obtained the bruise. Also, there was no indication the administrator or state agency was immediately notified of the incident. A subsequent note, dated 7/23/14, indicated R15 was found to have a 7.4 cm X 12 cm bruise when staff were completing morning cares. The note indicated R15 was not sure how it occurred and denied pain. The note did not provide any investigation regarding how R15 obtained the bruise. A separate incident report provided by the facility, dated 7/23/14, indicated staff noted another large bruise located on R15's upper left arm with morning cares. The report further indicated staff and R15 were unaware how the bruise occurred, as the skin concern were not of suspicious nature or location. The report did not indicate any investigation regarding how R15 obtained the bruise. Also, there was no indication the administrator or state agency was immediately notified of the incident as identified by the facility policy.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 11 R23's quarterly MDS, dated 7/18/14, indicated R23 was cognitively intact, demonstrated no behavioral symptoms, and took an anticoagulant medication 5 of 7 days during the review period. R23's Progress Note, dated 8/6/14, indicated R23 was noted to have a bruise on the right forearm measuring 15 cm X 10 cm. The note stated R23 was uncertain how she obtained the bruise. An incident report provided by the facility, dated 8/5/14, indicated R23 was noted to have a bruise on the right forearm measuring 15 cm X 10 cm in size. The report indicated they were uncertain what happened that caused the bruise, the area was not in a suspicious location, and had an extensive history of bruising related to Coumadin use. The report did not identify investigation regarding how R23 obtained the bruise. There was no indication the administrator or state agency was immediately notified of the incident as identified by the facility policy. R33's significant change in condition MDS, dated 6/18/14, indicated R33 had severe cognitive impairment, exhibited no behavioral symptoms, and did not take an anticoagulant medication. R33's Progress Note, dated 6/24/14, indicated R33 was noted to have a 5 cm X 2.8 cm bruise on his left forearm. An incident report provided by the facility, dated 6/23/14, indicated R33 had a bruise on the left forearm measuring 5 cm X 2.8 cm. The report further indicated, "Will not file a VA as not in a suscepious [sic] area." The report did not indicate any investigation regarding how R33 obtained the bruise. There was no indication	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 12 the administrator or state agency was immediately notified of the incident as identified by the facility policy. R38's quarterly MDS, dated 7/1/14, indicated R38 was cognitively intact, demonstrated no behavioral symptoms, and did not take an anticoagulant medication. R38's Progress Note, dated 7/27/14, indicated R38 to have a 3.5 cm X 0.2 cm skin tear/scratch with 6.5 cm X 3 cm of bruising surrounding it on his right forearm that was found by staff when doing morning cares. The note indicated staff was unsure of how it happened and the resident stated it happened last night, but was unable to provide details. An incident report provided by the facility, dated 7/27/14, indicated R38 was found to have a skin tear/scratch with bruising noted on his right forearm. The report stated resident stated it occurred last night, but was unable to identify specifics about how or when it occurred. Further, the report indicated the area was not in a suspicious location, and was not a reportable incident. The report did not identify any investigation regarding how R38 obtained the bruise. The note did not indicate any investigation regarding how R38 obtained the bruise, nor was the administrator and state agency immediately notified of the incident as identified by the facility policy. R42's quarterly MDS, dated 5/20/14, indicated	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 13 R42 had severe cognitive impairment, exhibited no behavioral symptoms, and did not take an anticoagulant medication. R42's Progress Note, dated 8/10/14, indicated R42 was found to have a large bruise on his right hip when being given a bath. Further, the note indicated the bruise to measure 15 cm X 16 cm, and R42 denied pain. The note did not provide any investigation regarding how R42 obtained the bruise. An incident report provided by the facility, dated 8/10/14, indicated R42 was noted to have a bruise measuring 15 cm X 16 cm discovered during his bath that evening. The report indicated R42 was unable to give a description for how he had obtained the bruise, was unsteady on his feet and the bruise was not in a suspicious location, so a report was not filed. The report did not contain any investigation regarding how R42 may have obtained the bruising nor was the administrator and state agency immediately notified of the incident as identified by the facility policy. R45's quarterly MDS, dated 6/27/14, indicated R45 had severely impaired cognitive skills, demonstrated no behavioral symptoms, and did not take an anticoagulant medication. R45's Progress Note, dated 7/16/14, indicated R45 had a 5 cm X 3 cm bruise on the top of her head that was found during her bath. The note further indicated staff nor R45 were sure how it may have occurred. The note did not indicate any investigation on how R45 obtained the bruise.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 14 An incident report provided by the facility, dated 7/16/14, indicated R45 was reported to have a "...large dark purple bruise", on her head. The report further indicated R45 was unable to give a description of what may have caused the bruise, but was not considered reportable because the area was not in a suspicious location, or of a suspicious size or shape. The report did not indicate any investigation on how R45 obtained the bruise, nor was the administrator and state agency immediately notified of the incident as identified by the facility policy. During interview on 8/20/14 at 11:50 a.m., the director of nursing (DON) stated an injury or bruise would have to be suspicious in size, nature, or location for the facility to report it as a concern. When interviewed on 8/21/14 at 10:39 a.m., licensed social worker (LSW)-A stated completing an investigation on each incident is important to rule out if abuse is occurring. LSW-A stated for R10, R15, R23, R33, R38, R42, and R45 should have been investigated and reported to the administrator and SA immediately as their policy identified. During a subsequent interview on 8/21/14 at 10:51 a.m., the DON stated the staff should investigate in order to look beyond the potential for just sexual abuse, but for physical abuse as well. The DON further stated there was not enough evidence to prove the incidents for R10, R15, R23, R33, R42, and R45 weren't abuse and should have been reported to the administrator and SA as their policy directed.	F 226		
F 258	483.15(h)(7) MAINTENANCE OF	F 258		9/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 258 SS=D	Continued From page 15 COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that noise levels did not affect resident comfort for 1 of 1 residents ((R24) reviewed for environmental concerns during hours of sleep. Findings include: R24's face diagnosis sheet, undated, indicated this resident had depression, anxiety and insomnia. The last quarterly minimum data set (MDS), dated 06/10/2014 indicated that this resident was independent with activities of daily living, and only required oversight with dressing and walking in the halls. The MDS further indicated no evidence of mood and/or behavior. R24 was assessed to be moderately cognitively impaired. However, in review of social service progress notes, dated 6/23/2014, documented that "resident is alert and orientated times 3". During interview on 8/19/14 at 9:07 a.m., R24 stated that she goes to bed between 9:00 -10:00 p.m., and "The young folks are talking loudly, it would be nicer if they considered that." R24 stated that she is a poor sleeper to start with and hallway noise makes it harder to sleep. Review of R24's monthly 3 night sleep assessment (entitled: Sleep Evaluation, form	F 258	F258 It is the intent of the Buffalo Lake Healthcare Center to provide comfortable sound levels throughout the facility. R24 has been interviewed and new interventions have been implemented and care plan updated to promote sleep for the resident. All residents have the potential to be affected by this deficient practice. The volunteer ombudsman will interview all residents to determine any concerns to be addressed on an individual basis. Interventions will be implemented and care plans updated as needed. The Director of Nursing/designee will perform walk through audits to monitor the noise levels in the facility. Any noise concerns will be brought to the QAA committee for review as needed. Corrective action will be completed by 9/30/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 258	Continued From page 16 undated), last performed 7/27/2014, indicated her sleep patter was "Fair" at four hours of sleep. In review of the sleep assessments from 6/27/14, 5/27/14 and 4/27/14, identified R24 had "Good" sleep which consisted of six hours. R24's care plan, with a print date of 8/21/2014, indicated that resident had insomnia (difficulty sleeping) and received trazadone (antidepressant) every evening for "treatment." The care plan went on to indicated that a monthly sleep evaluation would be completed, "maintain bedtime routine per R24's preference, administer medications as ordered by MD. Monitor for side effects and effectiveness...provide alternative comfort measures to promote sleep per R24's preference such as back rub, warm milk, repositioning, bedtime snacks." During resident interview on 8/20/2014 at 7:28 a.m., R24 stated again that her customary routine was she goes to bed between 9:00-10:00 p.m. each evening. Throughout the night she is awaken several times by "the young folks," talking loudly in the hallway and she has difficulty getting back to sleep. R24 stated has reported this concern of staff being loud at night, but was unable to provide any names, "I can't remember." During interview on 8/20/14 at 1:00 p.m., the director of nursing (DON) and the facility administrator (ADM) both stated they were unaware of this concerns, and added that R24 occasionally plays her organ between 9:00 p.m. to midnight. The DON further stated that the facility recently updated their pain assessment to include sleep issues, which would be performed at each quarterly review.	F 258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 258	Continued From page 17 In review of the facility's form, entitled: Pain Management (undated), the assessment was last performed on 6/10/14. Section 5, which was entitled Sleep information, documented that R24 did not feel she received a good night sleep, and further indicated that it was due to "Noise", which the form defined as, "i.e. carts, alarms, station doors, nurses talking, etc..". During interview on 8/21/2014 at 8:30 a.m., the DON stated after review of the 6/10/14 pain assessment, that they had thought the sleep disturbances reported were due to another resident, and did not investigate further. Although R24 had complained to the facility about noise at night and this was identified in her Pain Management assessment of not receiving "good sleep" and awaken by the noise at night. The facility did not address the noise level for R24.	F 258		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement instructions for splint application to prevent contracture (fixation of a joint) for 1 of 1 residents (R8)	F 318	F318 It is the intent of the Buffalo Lake Healthcare Center to ensure that residents with limited range of motion receive appropriate treatment and	9/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 18 reviewed for range of motion and positioning. Findings Include: During observation on 8/18/14 at 3:23 p.m., R8 had a yellow sign in his room taped to a cabinet which indicated, "BOTH (in bold lettering) hand splints to be on when [R8] is lying down during am and pm shifts". R8's left Restorative Hand splint was not applied as instructed on the sign, however this was sitting on his dresser. R8's quarterly Minimum Data Set (MDS) dated 5/2/14, indicated R8 had bilateral (both sides of the body) impairments in upper extremity range of motion, had a diagnosis of hemiplegia (paralysis of the arm, trunk, and leg on the same side of the body), and required total assistance to complete dressing. R8's care plan, dated 5/13/14, indicated R8 had limited physical mobility and left sided hemiparesis. Further, R8's care plan indicated an intervention of, "Bilateral hand splint program as established by therapy". Subsequent observations of R8 were made on 8/19/14 at 2:50 p.m. and 8/20/14 at 2:02 p.m., R8 was found to be in bed without the left hand splint being applied as directed by the instructions in his room. When interviewed on 8/20/14 at 1:15 p.m., nursing assistant (NA)-A stated she thought R8 was to only have the right hand splint on when in bed during the day. NA-A reviewed the instructions provided in R8's room regarding splint application and stated, "What we are doing is wrong then", further stating R8 should have the	F 318	services to increase range of motion and/or prevent further decrease in range of motion. R8□s splint program was reviewed and evaluated for appropriateness. His care plan has been updated and a new communication plan implemented for nursing staff to follow for splint/brace application. All residents with splints/braces have the potential to be affected by this deficient practice. All residents programs for splints/braces have been reviewed and care plans updated as appropriate. The Director of Nursing/designee will do random walk troughs of facility to monitor for appropriate splint/brace application. Any concerns will be brought to the QAA committee as needed for recommendations. Corrective action will be completed by 9/30/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 19 left hand splint applied when he is in bed during the day. During interview on 8/20/14 at 1:29 p.m., NA-B stated R8's left arm splint was only applied when he gets up in the morning into his wheelchair. NA-B further stated she never applied both when he was laying down in bed during the day, despite the instructions placed in his room, because a nurse told her it would be like a restraint. When interviewed on 8/20/14 at 1:22 p.m., registered nurse (RN)-A stated staff to follow the posted instructions for application provided by OT which are hung in his room, and the splint should have been put on when he layed down during the day. R8 should have the left hand splint on when he is napping in bed during the afternoon per OT (occupational therapy) instructions. During interview on 8/20/14 at 11:59 a.m., the director of rehabilitation (DOR) stated the instructions on the yellow sign placed in R8's room were the most recent instructions from OT for R8's hand splints and how they should be applied to reduce the risk of contracture. The DOR stated she expected nursing to be following the program as described in the instructions during a subsequent interview on 8/20/14 at 1:10 p.m.. When interviewed on 8/21/14, at 9:13 a.m., RN-B stated R8 should be having the hand splints applied according to what OT ordered. During interview on 8/21/14, at 9:44 a.m., the	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 20 director of nursing (DON) stated OT typically will set-up hand splint programs for the residents and place a posting in their room if they have certain instructions they would like nursing staff to follow. Further, the DON stated R8 should have had the left hand splint applied per OT instructions. A facility Range Of Motion/Splints/Braces policy, dated 2008, indicated a purpose of maintaining joint mobility and muscle strength along with preventing contractures, however did not provide specific instructions for reducing those risks by using splints or braces. The policy further stated to consult the physician or therapist for limitations or precautions for specific exercises.	F 318		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that resident falls were comprehensively assessed to help reduce the risk for potential falls for 5 of 5 residents (R10, R47, R36, R42, R59) who had falls. Findings include:	F 323	F323 It is the intent of the Buffalo Lake Healthcare Center to ensure that the resident□s environment remains as free of accident hazards as possible and each resident receives adequate supervision and assistance devices to prevent accidents. All residents identified by the deficient	9/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 21 R10's Admission Record (print date of 8/20/14) indicated that this resident had the diagnoses of: insulin dependant diabetes that is uncontrolled, congestive heart failure, coronary arteriosclerosis with bypass graft, and cerebral artery occlusion with infarct. A significant change minimum data set (MDS) dated 3/18/14, indicated that R10 required extensive assistance form one staff for most of his activity of daily living needs, and was moderately cognitively impaired. The Care Area Assessment (CAA) dated 4/24/14, indicated that R10 was at risk for falls, due to both health concerns and medication interventions, for which fall prevention interventions were listed. The quarterly MDS, 6/17/14 indicated that R10's ADL needs and cognition have worsen. R10's care plan, with a revision date of 7/28/14, indicated that he was identified as having falls risk due to impaired balance, shuffling gait and listed health issues and medication that further placed R10 at risk. Staff were directed to provide education for resident to wait for assistance for transfers, safe environment, call light in reach, anticipate resident needs and follow fall protocol if falls occurs. On observations of R10 on 8/18/14 at 4:20 p.m., 6:20 p.m., 8:00 p.m and on 8/21/14 at 10:30 a.m., R10 remained in bed and was only out of his room for meal times. A progress note dated 7/22/14 at 2:55 p.m. identified R10 was found on his hands and knees in front of an easy chairs. He was transferred from the floor to the bed with assistance of three staff. Review of an incident report, dated 7/22/14,	F 323	practice will have a fall risk assessment completed and interventions and care plan updated accordingly. All residents have the potential to be affected by the deficient practice. The facility will complete fall risk assessments on all residents and update care plans as necessary. The Director of Nursing/designee will complete audits on fall incidents to monitor for compliance. Any concerns with the fall risk process will be brought to the QAA committee as needed for review/recommendations. Corrective action will be completed by 9/30/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 22 indicated R10 was found on the floor in front of his easy chair on his hands and knees. He had been in the wheelchair prior to the fall and needed assistance of three staff, no evidence of pain. "Resident unable to provide fall information." There was no indication of how, or what may have caused R10 to fall. Review of R10's Fall Assessment, which was last completed on 5/17/11, identified he was a high risk for falls. There was no indication, that R10 had a current falls assessment even though he was identified at high risk for falls and had a fall on 7/22/14. During staff interview on 8/18/2014 at 5:34 p.m., the director of nursing (DON) stated that R10 had a fall on 7/22/14 and was found on the floor in his room, between his wheel chair and had no injuries after the fall. Although R10 was identified at high risk for falls, needed more assistance with ADL's, and had fallen on 7/22/14. The facility did not comprehensively reassess R10 falls, to determine why R10 had fallen and if the current interventions were appropriate to help reduce R10 risk of falls. R47's quarterly Minimum Data Set (MDS) dated, 5/23/14 identifies diagnosis of anemia, hypertension, dementia and traumatic brain injury. R47's had severe cognition, extensive assistance for all activities of daily living (ADL), transfers and ambulation. The MDS identified	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 23	F 323		

previous falls from a previous assessment period. The Care Area Assessment (CAA), dated 12/6/13 indicated difficulty maintaining sitting balance and impaired balance during transitions.

The care plan, dated 6/5/14, indicated a need for proper footwear, and no clutter in residents room. The nursing assistant (NA) care sheets dated 8/20/14 did not address fall risk reduction techniques that were identified in the care plan.

During observation on 8/19/14 at 12:38 p.m. R47 was sitting in his wheelchair and reaching over to straighten his bed. He then took his hat off and put it on the over bed table. R47 transferred himself into bed with the left brake on his wheel chair but the right brake was not on. He then rolled over into bed onto his right side and assumed the fetal position. R47 laid uncovered on top of the bedspread. During a later observation on at 2:30 p.m. R47 was lying in bed on his left side, sleeping, with a throw blanket wrapped around him.

During an observation on 8/20/14 at 6:56 a.m. R47 was lying in bed, appeared to be sleeping yet restless, on his back. A bed spread was pushed to the foot of the bed, the spread was wrapped within the bed sheets.

Review of the incident reports dated: 7/25/14, 8/2/14 and 8/7/14 all indicated R47 was found on floor with blankets around him. There was no assessment, analysis or action identified after R47's fall to prevent possible reoccurrence even though R47 was found with blankets wrapped around him.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 A safety/fall risk assessment was requested regarding R47's falls. However the facility was unable to provide one. During an interview on 8/19/14 at 3:33 p.m. the DON stated, "We took the blanket out of R47's room and gave it to the family and asked that it not be here since he trips in it." The blanket the DON was referring to was sent home; however, R47 had two more throw blankets in his room that were being used. Although R47 had multiple falls with blankets wrapped around him, the facility had not completed an assessment to determine appropriate interventions to help decrease R47 risk for potential falls. R36's annual MDS dated 6/20/14 identified diagnoses of dementia, depression, hypertension, diabetes mellitus. It also indicates R36 had severe cognition, and needed extensive assistance for bed mobility and ADL's. The MDS also identified one fall without injury and one fall with injury in the previous assessment period. The CAA, dated 7/3/14 indicated some falls occurred in May during "usual activity" and R36 had impaired balance needed to use a front wheel walker and a silent alarm was applied. The care plan dated 8/7/14 included appropriate footwear, no clutter in room, silent alarms while in bed and in the recliner and physical therapy and occupational therapy to evaluate and treat as ordered as needed. The NA care sheets (undated) indicated the use of a silent alarm, and did not include other interventions to prevent potential falls for R36.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 25 During an observation on 8/19/14 at 12:57 p.m. R36 sitting in his recliner in his room visiting with his company. There was no indication a silent alarm was on the resident while he was in the recliner. During observation on 8/20/14 at 7:03 a.m. R36 was asleep lying on his back in bed with an alarm attached. An incident report dated 7/21/14 indicated R36 had a fall, "Bed alarm sounding found resident lying on his back in the middle of the room with his pajama bottoms and briefs down around his ankles..." The report also identified R36 was drowsy and incontinent. There was no assessment, analysis or action identified after R36's fall to prevent possible reoccurrence. A safety/fall assessment was requested, however the facility was unable to provide one. Even though R36 had falls, the facility had not implemented their interventions, nor was a comprehensive assessment completed to determine if there was a patterns to the falls, and what interventions were effective to help decrease R36's risk of potential falls. R42's quarterly MDS dated 5/20/14, identified diagnoses of dementia, Alzheimer's disease, anxiety, depression and hypertension. It also indicates R42 had severely cognitively impaired, required supervision for all ADL, and needed assistance of one for transfers and ambulation. The MDS also indicated R42 had one fall without injury in the previous assessment period. The	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 26 CAA, dated 9/6/2013 indicated R42 had difficulty maintaining sitting balance, standing position, had gait problems, and impaired balance. An incident report provided by the facility dated 8/2/14 indicated "resident was found laying on the floor on his back. He was resting his head in his arms." No evaluation, analysis or action was recorded after this fall to prevent reoccurrence. A safety/fall risk assessment was requested, however the facility was unable to provide one. An observation on 8/21/14 at 10:15 a.m. R42 sitting in a recliner with his legs up on the foot rest, in his room. The care plan dated 5/29/14 indicates R42 is at high risk for falls. The NA care sheets dated 8/21/14 does not address fall risk reduction techniques. Although R42 had falls, the facility had not assessed these falls to determine appropriate interventions were implemented to decrease R42 potential falls. R59's initial MDS dated 8/15/14, identified diagnosis of history of falls, anxiety, depression, hypertension, diabetes mellitus. It also indicates R59 was cognitively intact, needed extensive assistance of ADL's, bed mobility and transfers. Limited assistance for ambulation. The MDS also indicates a history of falls with injury before admission. The CAA dated 8/19/14, indicated difficulty maintaining sitting balance and impaired sitting balance. An incident report provided by the facility dated	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 27 8/19/14, indicated "...resident sitting on the floor in the middle of the room. The walker was to the right of him and the wc behind him..." No evaluation, analysis or action was identified to prevent fall reoccurrence. A safety/fall risk assessment was requested, the facility was unable to provide one. An two observation on 8/21/14 at 9:10 and 10:16 a.m. R59 was sitting in a high back chair sleeping with a walker to his right and was not within his reach. The care plan, dated 8/20/14 identified problem of falls with the interventions as appropriate footwear and lighting. The NA care sheets dated 8/21/14, only identified alarms for R59. Although R59 had a history of falls, and fell on 8/19/14, the facility did not assess the falls to ensure appropriate interventions were implemented to help decrease his risk of falls. An interview with the DON on 8/19/14 at 12:07 p.m. said the staff get away from doing documentation on how an incident happened and doing root cause analysis. She stated the outcomes are documented on the progress note and the care plan. She agreed an assessment was not competed to determine appropriate interventions to help decrease potential falls. The DON further stated "we don't document information from the falls when discussed at the interdisciplinary team meeting, we discuss the 24 hour sheets". We don't talk about any individual incidents at safety committee, we just review the data. In review of the facility policy, entitled: Resident	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	08/21/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 28 Incident/Accident Assessment and Documentation related to Falls, last revised 2/14, the policy's procedure documentation needed on the initial accident/incident report was as follows: #5 If possible, obtain an explanation from the resident. #7 describe devices in place at the time, #9 a change in mental status, #12 any possible contributing factors , #`13 any immediate intervention to prevent a reoccurring incident. Also section interdisciplinary team assessment follow-up and tracking, #2 interventions that were implemented by the nursing staff will be evaluated for effectiveness and any other new interventions will also be implemented. At this time, the nurse manager will check that all of the necessary documentation is recorded in the correct places A. Nurses notes B. Care plan C. Nurse and nursing assistant task list D. Other departmental documentation such as dietary intervention, a physical therapy or restorative interventions or activities. The safety patient handling and safety committee meeting minutes dated July 16, 2014 were reviewed. The minutes did not address individuals and how to ensure a safe environment.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/21/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 21, 2014. At the time of this survey, Building 01 of Buffalo Lake Healthcare Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Building 01 of Buffalo Lake Healthcare Center was constructed as follows: The original building was constructed in 1960, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 1st Addition was constructed in 1965, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 2nd Addition was constructed in 1982, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 3rd Addition was constructed in 1993, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction. Building 01 is separated from both Building 02, and an attached assisted living facility, by proper two-hour fire wall assemblies. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a	K 000	EPOC	

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

Electronically Signed — 09/16/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/21/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 capacity of 49 beds and had a census of 48 at time of the survey. .	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING **02 - 2012 BUILDING ADDITION** B. WING _____	**08/21/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 21, 2014. At the time of this survey, Building 02 of Buffalo Lake Healthcare Center 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) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

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

Electronically Signed | 09/16/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING **02 - 2012 BUILDING ADDITION** B. WING _____	**08/21/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By eMail to: 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. Building 02 of Buffalo Lake Healthcare Center consists of the 2012 and 2014 resident room additions. Building 02 is one-story in height, has no basement, is fully sprinklered and was determined to be of Type V (111) construction. Building 02 is separated from Building 01 by proper two-hour fire wall assemblies. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 49 beds and had a census of 48 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching	K 018		8/25/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING **02 - 2012 BUILDING ADDITION** B. WING _____	**08/21/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 2 hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain one or more corridor doors in the means of egress in accordance with the requirements at NFPA 101 (2000) Chapter 18, Section 18.3.6.3. This deficient practice could adversely affect 18 of 49 residents. FINDINGS INCLUDE: On 08/21/2014 at 12:10 PM, observation revealed the corridor door to the Clean Linen Room on the 400-Wing corridor failed to positively latch into the frame, as the door latch was out of adjustment. This deficiency was verified with the chief building engineer at the time of discovery.	K 018	K 018 Completion Date: August 25, 2014 It is the intent of the Buffalo Lake Healthcare Center to maintain all corridor doors in the means of egress in accordance with NFPA 101 (2000) Chapter 18, Section 18.3.6.3. The Administrator and Maintenance Supervisor will be responsible for maintaining the corridors doors in the means of egress so that they positively latch into the frame.	