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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: W1B9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00714

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2004**

6. DATE OF SURVEY **02/13/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
01/31

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (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
	56			
(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 :
Kerry Queen, DSFM — 02/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 02/14/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 02/15/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/09/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245513
February 14, 2017

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

Dear Mr. Nelson:

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

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

Effective January 30, 2017, the above facility is certified for or recommended for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds located in rooms .

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
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 14, 2017

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

RE: Project Number S5513026

Dear Mr. Nelson:

On January 12, 2017, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 10, 2017. (42 CFR 488.417 (b))

Also, we notified you in our letter of January 12, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 10, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on November 10, 2016, and lack of verification of substantial compliance with the health deficiencies at the time of our January 12, 2017 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On January 18, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 10, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 15, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 10, 2016, as of December 15, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of January 12, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 10, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective February 10, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective February 10, 2017, is to be rescinded.

In our letter of January 12, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 10, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on December 15, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 12, 2017

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

RE: Project Number S5513026

Dear Mr. Nelson:

On December 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 10, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

However, compliance with the health deficiencies issued pursuant to the November 10, 2016 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 10, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective February 10, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 10, 2017. You should notify

all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Lake Ridge Care Center Of Buffalo is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 10, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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

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 May 10, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245513 Y1	A. Building B. Wing Y2	1/18/2017 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279	Correction	ID Prefix F0280	Correction	ID Prefix F0309	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.25	Completed
LSC	12/12/2016	LSC	12/15/2016	LSC	12/15/2016
ID Prefix F0313	Correction	ID Prefix F0329	Correction	ID Prefix F0431	Correction
Reg. # 483.25(b)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	12/15/2016	LSC	12/15/2016	LSC	12/15/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 02/14/2017	SIGNATURE OF SURVEYOR 33925	DATE 01/18/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/10/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245513 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/13/2017 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0131	Correction Completed 01/30/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** TL/KJ	**DATE** 02/14/2017	**SIGNATURE OF SURVEYOR** 19251	**DATE** 02/13/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 12/8/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: W1B9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00714

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2004**

6. DATE OF SURVEY **11/10/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
01/31

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(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 :
Timothy Rhonemus, HFE NE II — 12/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 01/06/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 01/9/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 15, 2016

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

RE: Project Number S5513026

Dear Mr. Nelson:

On November 10, 2016, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) , 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:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

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

the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 20, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC

must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 10, 2017 (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 May 10, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
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
	245513	A. BUILDING _____ B. WING _____	11/10/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279		12/12/16

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

Electronically Signed | 12/15/2016

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F 279	Continued From page 1 by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan for 1 of 1 residents (R36) who was identified as a smoker. Findings include: R36's quarterly Minimum Data Set (MDS) dated 8/30/16, identified R36 had moderate cognitive impairment, and required extensive assistance with transfers and mobility. During observation on 11/8/16, at 6:06 p.m. R36 was observed in her wheelchair going outside the facility with her husband to the edge of the nursing home parking lot. R36's husband lit a cigarette and handed it to his wife. R36 was able to hold the cigarette, ash safely, and smoke independently. When R36 was done smoking, she handed the cigarette to her husband to extinguish. R36 smoked the entire cigarette with only her husband present. During interview on 11/8/16, at 6:08 p.m. R36 stated she smoked two cigarettes a day, one after lunch and one after supper. Further, R36 stated her husband took her outside to smoke and she only smoked when he was with her outside. R36's Smoking Risk Observation dated 9/21/16, identified R36 was a current smoker who smoked a, "Couple times per day." Further, the observation identified R36 was safe to smoke and her care plan developed, "Plan of Care Updated." R36's care plan dated 11/2/16, lacked any information on R36's smoking habits, abilities, or	F 279	F279-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to develop comprehensive care plans for those residents that are identified as a smoker. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The care plan for R36 was reviewed and revised prior to 10 Nov 2016 regarding their smoking. 2.Actions taken to identify other potential residents having similar occurrences: Current residents in the facility will be interviewed about their current smoking status. Those residents identified as wanting to smoke will have their comprehensive care plan reviewed and revised. 3.Measures put in place to ensure	

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F 279	Continued From page 2 interventions for staff to implement to assure she remained safe while smoking with her husband. When interviewed on 11/8/16, at 6:53 p.m. nursing assistant (NA)-D stated she was unaware if R36 was a smoker or not, nor if there were any interventions to ensure she smoked safely. During interview on 11/9/16, at 6:21 a.m. NA-C stated she was not aware R36 was a smoker, nor if there were any interventions to ensure she smoked safely. When interviewed on 11/9/16, at 7:13 a.m. NA-E stated R36 was not a smoker to her knowledge, nor if there were any interventions to ensure she smoked safely. During interview on 11/9/16, at 12:23 p.m. registered nurse (RN)-A stated R36 had been assessed to be safe with smoking, however the care plan had not been updated as indicated by the assessment. Further, RN-A stated R36's daily smoking should have been included on her care plan. When interviewed on 11/10/16, at 10:01 a.m. a director of quality registered nurse (RN)-B stated all resident's should be monitored for safety. Further, RN-B stated all resident assessment and safety needs should always be documented in a resident's care plan. A facility policy on care planning was requested, but was not provided.	F 279	deficient practice does not recur: At quarterly and annual MDS assessments, and upon admission, residents will be interviewed about their smoking status, including those that are current or past smokers. Any resident that has a positive smoking preference will be given to nursing to perform appropriate smoking assessments and the comprehensive care plan can be created and/or updated. 4.Effective implementation of actions will be monitored by: All current residents will be interviewed by 12 Dec 2016 to determine their smoking preference and quarterly thereafter. All residents will have their comprehensive care plans reviewed and revised as necessary upon admission and with their quarterly comprehensive care plan review. Performance will be monitored by report submission to the Quality Assurance Committee for the next two quarterly meetings. 5.Those responsible to maintain compliance will be: The Director of Nursing, or their designee, will be responsible for ensuring comprehensive care plans are created, reviewed and revised for those residents that are identified as smokers.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		12/15/16

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F 280	Continued From page 3 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on Observation, interview and document review, the facility failed to revise the care plan to include new fall interventions for 1 of 3 residents (R69) who had a history of falls. Finding include: R69's medical record indicated the diagnoses of Parkinson's diease and weakness. The significant change minimum data set (MDS), dated 10/20/16, required extensive assistance of 1-2 staff for all activities of daily living. The Care Area Assessment (CAA) for Falls (dated 10/20/16), indicated R69 was at a high risk for falls due to weakness, unsteadiness, Parkinson's, and was	F 280	F280-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same.	

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F 280	Continued From page 4 impulsive at times attempting self transfers. The CAA further indicated that R69 was currently involved with both occupation and physical therapy. During review of R69's falls during the months of August through November 2016 (11 falls in total), the facility had documented on the Fall Scene Investigation Report (FSI) that dycem (a sticky gelled pad) would be placed in R69's room recliner. This was a result of a fall on 9/1/16 when R69 fell from his recliner while bending forward to check his shoe. In review of R69's care plan (last edited 11/8/16) and nursing assistant care sheet (undated) did not direct staff to make sure the dycem was placed in R69's recliner for fall prevention. In observations performed on 11/8/2016 from 6:00 p.m. through 7:10 p.m., and on 11/9/16 at 12:55 p.m., R69 was observed in his room vinyl recliner with only a thick covered foam cushion with a nylon cover in his recliner. This was no gel cushion identified during these observations. During interview on 11/08/2016 7:30 p.m. with nursing assistant (NA) - A, the NA was unaware of any special checks or devices that R69 needed in place for fall prevention other than his call light. An interview on the same day at 7:34 p.m. with NA-B also indicated that, other than the call light no other safety devices or interventions were care planned. On 11/9/16 at 2:47 p.m., during interview with NA-C, after looking at her printed care sheet, stated that (R69) was to have his at besides his glasses and beverages within reach. Staff were to	F 280	It is the policy of Lake Ridge Care Center to revise care plans to include new fall interventions for residents who have a history of falls. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The care plan was revised with all previous fall interventions from the FSI forms and reviewed with the ID Team on 22 Nov 2016. 2.Actions taken to identify other potential residents having similar occurrences: Residents who have a history of falls that have fallen at the facility could potentially be affected. 3.Measures put in place to ensure deficient practice does not recur: Current residents with a history of falls will have their care plans reviewed and revised to ensure fall interventions are in place by 15 Dec 2016. Falls will continue to be reviewed at appropriate ID Team morning meetings; FSI forms will be signed and returned to unit manager to update the NAR care sheets and review and revise the comprehensive care plan. After NAR care sheets and comprehensive care plans have been updated, the FSI form will be returned to the Director of Nursing for reporting purposes. 4.Effective implementation of actions will be monitored by:	

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F 280	Continued From page 5 make sure that R69's call light was within reach. In an interview with a nursing care coordinator (CC)-A on 11/10/16 at 10:01 a.m., the CC-A stated that when the interdisciplinary team reviews resident falls, any interventions decided on should be placed both in the resident care plan and the nursing assistant care sheets. This interventions had not been added to the care plan or NA care sheets.	F 280	The Director of Nursing will continue to audit falls to ensure care plans are reviewed and revised to include new fall interventions, no less than monthly for the next six months. Audit findings will be reported to the next two quarterly Quality Assurance committee meetings. 5.Those responsible to maintain compliance will be: The Director of Nursing, or their designee, and unit managers are responsible for ensuring care plans are revised to include new fall interventions on residents who have a history of falls.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to comprehensively assess and monitor for symptoms of hyperglycemia (high blood sugar) for 2 of 2 residents (R26, R36) who had high blood sugar reading. Findings include: R26's quarterly Minimum Data Set (MDS) dated	F 309	F309-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission	12/15/16

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F 309	Continued From page 6 10/20/16, identified R26 had severe cognitive impairment with a diagnosis of type two diabetes mellitus (metabolic disease causing increase blood glucose levels and may require insulin) and received Novolog 70/30 (insulin used for diabetes) 16 units subcutaneous (SQ) in the morning and 4 units sliding scale SQ for blood sugars over 300. Further, R26 received Novolin (insulin used for diabetes) 8 units SQ at supper. A signed physician order dated, 5/2/16, identified, " Notify the medical doctor if blood glucose is less than or equal to 70 and symptomatic or greater than or equal to 350 and symptomatic. Document "yes" or "no" if symptoms present." Review of R26's care plan dated 5/18/16, identified R26 was at risk for hyper or hypo glycemia episodes related to diabetes with a goal of, "blood glucose will be between 70-250 Milligrams per Deciliter (mg/dL) ." The care plan further identified interventions for R26 which included, nursing to check blood sugar levels as ordered/as needed, monitor daily for signs/symptoms of hypo/hyper glycemia and to notify the medical doctor as needed. Review of R26's medication treatment record (TAR) for blood glucose monitoring from August 2016 through November 2016 identified the following irregularities; August 2016- 8/3/16- 355 mg/dL, 8/9/16-446 mg/dL and 8/20/16-398 mg/dL with no nursing assessment identified if R26's was symptomatic or asymptomatic for hyperglycemia. September 2016- 9/6/16- 393 mg/dL 9/22/16- 356 mg/dL, 9/23/16 -413 mg/dL, 9/25/16- 373	F 309	against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to comprehensively assess and monitor for symptoms of hyperglycemia for residents who have high blood sugar readings. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Licensed staff were re-trained on the signs and symptoms of hyperglycemia; any resident outside of physician ordered parameters will have a focused assessment and symptoms and interventions will be documented in the progress notes. 2.Actions taken to identify other potential residents having similar occurrences: Residents with a diagnosis of diabetes could potentially be affected by high blood sugar readings. 3.Measures put in place to ensure deficient practice does not recur: Current accucheck orders and parameters will be reviewed and revised with the medical director on 8 Dec 2016. Licensed staff and TMA's will be trained on the signs and symptoms of hyperglycemia, correct documentation in Matrix, notification of physician	

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F 309	Continued From page 7 mg/dL and 9/30/16- 403 mg/dL with no nursing assessment identified if R26 was symptomatic or asymptomatic for hyperglycemia. October 2016- 10/1/16-398 mg/dL, 10/3/16-402 mg/dL, 10/15/16-417 mg/dL, 10/18/16- 395 mg/dL, 10/20/16- 409 mg/dL, 10/21/16-353 mg/dL, 10//22/16-383-dL, 10/24/16-389 d/L, 10/29/16-389 mg/dL, and 10/31/16-353 mg/dL with no nursing assessment identified if R26 was symptomatic or asymptomatic for hyperglycemia. When interviewed on 11/10/16, on 9:39 a.m. the consultant pharmacist (CP) stated it was the facilities responsibility to monitor R26's blood sugar and to assess whether R26 was symptomatic or asymptomatic and to notify the physician. During interview on 11/10/16, at 10:49 a.m. medical director (MD)-A stated the facility did not have a sufficient process in place for monitoring and documenting R26's blood sugars. Further, MD-A stated it was his expectation facility staff would complete an assessment of (R26's) hyper glycemia symptoms as if she was symptomatic the facility staff would need to contact her (R26's) physician to determine if further medical interventions were needed. When interviewed on 11/10/16, at 1:27 p.m. the director of nursing (DON) stated it was her expectation facility staff would monitor for symptoms of hypo/hyper glycemia if R26's blood sugar was less than 70 or greater than 350 and to notify the physician as it may be an indication of a "diabetic emergency" which may need further medical assessment and interventions.	F 309	procedures and diabetic management by 15 Dec 2016. 4.Effective implementation of actions will be monitored by: Symptomatic high blood sugars will be monitored during daily ID Team meetings. Correct assessments and progress notes will be monitored weekly for three months . Performance will be shared with the next quarterly QA meeting for ongoing monitoring. 5.Those responsible to maintain compliance will be: The Director of Nursing, or designee, will be responsible for ensuring high blood sugar readings are comprehensively assessed and monitored for symptoms of hyperglycemia.	

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F 309	Continued From page 8	F 309		

R36's diagnoses, as identified on the quarterly Minimum Data Set dated 8/30/16, included Type 2 diabetes mellitus. The MDS also indicated R36 received daily insulin injections.

A Physician 's Order Report, dated 11/10/16, indicated R36 received Novolin 70/30 Insulin (a combination insulin medication) 25 units every morning subcutaneously, and 8 units every evening. Another 11/10/16 dated physician ' s order directed R36 to have " Accu check " (monitoring of blood sugar via a finger stick test) daily before meals. The order directed to call MD/NP (doctor or nurse practitioner) if R36 ' s blood sugar was greater than or equal to 350 mg/dl (milligrams per deciliter, a measurement of blood glucose level), and symptomatic (that is, exhibiting signs of elevated blood sugar levels such as frequent urination, being sweaty, trouble concentrating or blurred vision). The MD/NP were also to be notified if R36 was asymptomatic, and the blood sugar results were greater than or equal to 350 mg/dl for 3 consecutive "accu checks."

R36's blood sugar results from 9/7/16 to 11/7/16 were reviewed. A progress note dated 9/24/16 indicated R36's blood sugar at 11:21 a.m. was 368 mg/dl, and the nurse administered prn (as needed) insulin as ordered. There was no indication in the progress note or administration record if R36 exhibited signs of elevated blood sugars or was asymptomatic. R36 ' s blood sugar on 10/15/16 at 4:49 p.m. was documented at 419 mg/dl. There was no indication in the medication administration record, nor in progress notes, if R36 was symptomatic or not due to the elevated blood sugar level, or if it was necessary that the doctor or nurse practitioner were notified.

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	245513	A. BUILDING _____ B. WING _____	11/10/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 9 During an interview on 11/10/16 at 1:31 p.m., registered nurse (RN)-D said each resident who is diabetic has unique orders and different set of parameters as to when to administer insulin, when to hold insulin, and when to call the doctor. RN-D stated that " each time " blood sugar is measured, a residents symptoms, if there are any, should be assessed and documented. RN-D also said it should be documented even when a resident presents with no symptoms. RN-D said in the case of (R36), it would be important to know if she had symptoms with an elevated blood sugar so consecutive blood sugars can be compared. RN-D stated, " How else could you keep track? " In an interview on 11/10/16 at 1:56 p.m., RN-A said R36's order was to call the provider if her blood sugar was greater than 350 [mg/dl] and she was symptomatic, or if R36 was not symptomatic, but the next three consecutive blood sugars were greater than 350 mg/dl. RN-A said there was no real way to know to notify the next nurse if R36 was asymptomatic, with an elevated blood sugar level. RN-A said she would not expect the nurses to always be compliant writing a progress note each time, but that it "could be easily fixed" in the charting to add a spot to document, at least yes or no, if a resident had symptoms of elevated blood sugars. A policy was requested on blood glucose monitoring, but was not provided during the survey.	F 309		
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION	F 313		12/15/16

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F 313	Continued From page 10 To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to assist in finding or scheduling transportation to get glasses for 1 of 1 residents (R3) reviewed for vision. Findings include: R3's quarterly Minimum Data Set (MDS) dated 10/616, identified R3 was cognitively intact, had impaired vision and could not view regular print material such as newspaper or books. R3's care plan dated 10/22/16, identified, "R3 has impaired vision and reads large print better than regular prints" with a goal of " R3 will continue to have the ability to read large print without the use of glasses through the next review date." R3's signed physician orders dated 1/20/16, identified R3 needed new glasses prescription due to diabetes and mild retinopathy. Review of nursing notes dated 12/29/15, identified R3 had an optometry appointment scheduled for 1/7/16 due to R3's request for reading glasses. On 1/22/16, R3 had a new	F 313	F313-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to assist in finding or scheduling transportation to get glasses for those residents reviewed for vision. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident R3 had transportation arranged and attended an eye appointment on 2	

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F 313	Continued From page 11 prescription for reading glasses. A subsequent nursing note dated 1/26/16, identified R3 was refusing to get his eye prescription filled and no transportation or appointment was made for his (R3's) eye glasses. During interview with R3 on 11/7/15, at 10:28 a.m. R3 stated, "I wished I had my reading glasses" because he was having problems reading fine print. Further, R3 stated he declined transportation in January 2016 because he could not "afford transportation costs" and the facility had not made any other attempts to discuss transportation arrangements with him (R3) throughout the year. When interviewed on 11/9/16, registered nurse (RN)-A stated R3 had requested a optometry appointment in October 2015 and the unit secretary was responsible for setting up appointments within the facility. During interview on 11/10/16, at 9:14 a.m. health unit coordinator (HUC) stated R3 had prescription eye glasses before being admitted to the facility in June 2015. Further, HUC stated it was the HUC's responsibility to set up transportation for optometry appointments and if residents were having issues with transportation costs she could coordinate with the social worker to help find affordable transportation options. A facility policy on vision was requested, but none was provided.	F 313	Dec 2016; eyeglasses will be mailed to the facility in one month. 2.Actions taken to identify other potential residents having similar occurrences: Any resident reviewed for vision have the potential to be affected by transportation issues. Current residents reviewed to ensure vision needs are met. 3.Measures put in place to ensure deficient practice does not recur: All residents assessed for vision concerns upon admission or identified on the quarterly MDS as impaired vision will be have appointments made for follow-up by the Health Unit Coordinator, completed by 15 Dec 2016. Appointments will be monitored for completion; if an appointment is cancelled, the Health Unit Coordinator will re-approach the resident to reschedule. If an appointment cannot be rescheduled, the Health Unit Coordinator will inform a licensed nurse to assess the resident and explain the risks and benefits of not rescheduling the appointment. 4.Effective implementation of actions will be monitored by: Appointment scheduling will be monitored on an ongoing basis and will be reviewed by the Director of Nursing, or their designee monthly and those appointment cancellations will be shared at the next two quarterly QA meetings. 5.Those responsible to maintain compliance will be:	

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F 313	Continued From page 12	F 313	The Health Unit Coordinator is responsible for arranging transportation for those residents identified with vision needs.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure non-pharmacological interventions and behavior monitoring were	F 329	F329-D Facility timely submits this response and plan of correction pursuant to federal and	12/15/16

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F 329	Continued From page 13 completed prior to administering anti-anxiety medications for 1 of 5 residents (R26) reviewed for unnecessary medications. R26's quarterly Minimum Data Set (MDS) dated 10/26/16, indicated R26 had severe cognitive impairment with a diagnosis of unspecified dementia without behavioral disturbance, major depressive disorder and generalized anxiety disorder. R26's Care Area Assessment (CAA) dated 8/02/16, noted R26 had no behaviors or psychosis and was an extensive assistance of two with activities of daily living (ADL's). R26's care plan dated 08/02/16, indicated R26 had an identified problem of, "alteration in mood: resident receives antidepressant medication related to a diagnosis of depression and pain. She does have times when she may feel anxious. Resident may become weepy, anxious, restless and has needed and continue to receive an antidepressant as ordered." Interventions for R26 included; exploring possible reasons for R26's distress and to monitor/record/report mood and response to medication, document observed target behaviors and therapeutic goals. Review of R26's medication administration record (MAR) indicated R26 had an order for lorazepam (medication used to treat anxiety) 0.25 milligrams (mg) tablet three times a day as needed for generalized anxiety disorder. The as needed medication administration record identified the time, reason for administration, non-drug approaches and the result of the as needed medication.	F 329	state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to ensure non-pharmacological interventions and behavior monitoring are completed prior to administering anti-anxiety medications. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Non-pharmacological interventions were reviewed and specific behaviors were identified for R26. Reviewed assessment and identification of target behaviors, non-pharmacological interventions and appropriate documentation with licensed nurses. 2.Actions taken to identify other potential residents having similar occurrences: Residents that have orders for anti-anxiety medications have the potential to be affected in the same manner as the cited resident. 3.Measures put in place to ensure deficient practice does not recur:	

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F 329	Continued From page 14 Review of the MAR identified the following: In August 2016, R26 took her as needed lorazepam on 5 different occasions of which 3 episodes did not identify any non-pharmacological interventions used and 2 separate occasions did not document any behaviors. In September 2016, R26 took her as needed lorazepam on 8 different occasions of which in 4 episodes did not identify any behaviors and 3 occasions did not identify if any non-pharmacological interventions were attempted prior to the use of the medication. In October 2016, R26 took 6 doses of lorazepam of which 4 episodes did not identify any behaviors and 3 occasions did not have any non-pharmacological interventions were attempted prior to the use of the medication. Review of R26's pharmacist drug regimen review on 4/26/16, the consultant pharmacist (CP) indicated facility staff needed to ensure non-pharmacological approaches were documented for R26's as needed lorazepam. On 10/6/16, the CP again indicated the documentation on R26's lorazepam was "much improved", but the facility needed to continue to remind staff about documenting symptoms of anxiety and non-pharmacological interventions. During interview on 11/10/16 at 9:39 a.m., the consultant pharmacist (CP) stated facility staff were expected to document non-pharmacological interventions and behaviors prior to administering the as needed lorazepam. Further, CP stated	F 329	All current residents that have anti-anxiety medication orders will be reviewed for non-pharmacological interventions and behavior monitoring by 12 Dec 2016. New admissions that have anti-anxiety medication orders will be assessed, upon admission, for non-pharmacological interventions and behavior monitoring. Licensed nurses and TMA's will receive education regarding anti-anxiety medication orders, non-pharmacological interventions and behavior monitoring, as well as proper documentation by 15 Dec 2016. 4.Effective implementation of actions will be monitored by: Residents that have orders for anti-anxiety medications will be audited to ensure non-pharmacological interventions and behavior monitoring are completed prior to anti-anxiety medication being administered weekly for four weeks and then monthly for three months. Findings will be reported at the next two quarterly QA meetings for performance improvement. 5.Those responsible to maintain compliance will be: The Director of Nursing, or designee, will be responsible for ensuring non-pharmacological interventions and behavior monitoring is completed prior to administering anti-anxiety medications.	

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F 329	Continued From page 15 recommendations for further documentation on target behaviors and non- pharmacological interventions had been brought up at the Quality Assurance and Assessment Committee in the past year. When interviewed on 11/10/16 at 10:49 a.m., the medical director (MD) stated it was his expectation facility staff were to document, behaviors and non-pharmacological interventions prior to the use of the medication and chart this accordingly so R26's behaviors could be efficiently track/trended. During interview on 11/1/16, at 1:27 p.m. the director of nursing (DON) stated it was important for facility staff to document non-pharmacological interventions and behaviors to evaluate the effectiveness of the as needed lorazepam.	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		12/15/16

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F 431	Continued From page 16 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired Lantus insulin (medication used to treat diabetes) vial was removed from medication carts and administered to 1 of 1 residents (R3) who used this Lantus insulin. Findings include: R3's quarterly Minimum Data Set (MDS) dated 7/9/16, identified R3 had type two diabetes mellitus (metabolic disease causing increase blood glucose levels and may require insulin) and received Lantus (insulin used for diabetes) 34 units subcutaneous (SQ) in the morning. During observation on 11/7/16, at 9:22 a.m. R3 had an outdated Lantus insulin vial with an expiration date of 10/22/16 located in the Mill	F 431	F431-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to ensure that expired diabetic medications are removed from the medication cart.	

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F 431	Continued From page 17 Creek medication cart. During interview on 11/7/16, at 9:22 a.m. RN-C verified the Lantus insulin was expired and stated R3 had been administered 11 doses of expired Lantus insulin from 10/23/16 though 11/6/16. Further, RN-C stated there were no other Lantus insulin vials for R3 located on the medication cart. During interview on 11/8/16, at 1:38 p.m. the director of nursing (DON) stated nursing staff should be checking the expiration dates on a daily basis before administering a dosage of insulin. Further, DON stated she believed Lantus insulin expired after 28 days and the purpose of not using expired insulin was to ensure its efficiency. A package insert for Lantus was requested during the survey, but was not provided. A review of manufacturer product information by Sanofi, identified: "Do not use LANTUS after the expiration date stamped on the label or 28 days after you first use it". The product information further identifies under storage information: "The LANTUS vials you are using should be thrown away after 28 days, even if it still has insulin left in it." An undated facility policy, "Diabetes Management" directed once multidose vials of Lantus are opened for administration, they are considered stable for up to 28 days. A facility policy titled, "Storage and Expiration of Medications, Biological's, Syringes and Needles" dated 01/2013, identified, "Medications and biological's have not been retained longer than recommended by manufacturer or supplier."	F 431	To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The expired insulin medication was removed from the medication cart. 2.Actions taken to identify other potential residents having similar occurrences: Any diabetic resident had the potential to be affected by expired diabetic medications. 3.Measures put in place to ensure deficient practice does not recur: New expiration stickers have been ordered to make tracking expirations more consistent and all nurses and TMA's were updated on this change at the all staff meeting on 16 Nov 2016. Cart audits were started on 18 Nov 2016; licensed staff and TMA's will be in-serviced on medication passes and expiration dates by 14 Dec 2016. 4.Effective implementation of actions will be monitored by: Insulin audits on the medication carts will be performed weekly for one month, bi-weekly for one month and monthly for three months; audit performance will be submitted to the next two quarterly QA meetings. 5.Those responsible to maintain compliance will be: Director of Nursing, or designee, will be responsible to ensure that expired	

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F 431	Continued From page 18	F 431	diabetic medications are removed from the medication cart.	

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	245513	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/08/2016**

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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 December 08, 2016. At the time of this survey, Lake Ridge Care Center was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101 Life Safety Code (LSC), Chapter 19 Existing 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 St., Suite 145 St Paul, MN 55101-5145, or	K 000	EFOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/26/2016

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

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LAKE RIDGE CARE CENTER OF BUFFALO	**310 LAKE BOULEVARD** **BUFFALO, MN 55313**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@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 The facility will be surveyed as two separate buildings. Lake Ridge Care Center is a 2-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(111) construction. In 1976, an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. 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 56 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245513	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/08/2016**

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K 131 SS=F	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: * They are not intended to serve four or more inpatients. * They are separated from areas of health care occupancies by construction having a minimum 2-hour fire resistance rating in accordance with Chapter 8. * The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility did not maintain the proper fire separation between the Nursing Home and the Assisted Living facility not in accordance with LSC (2012) edition section 9.7, and 19.1.3.3. The deficient practice could affect 24 residents in the event of a fire. Findings include: On facility tour between the hours of 1:30 PM and 5:30 PM on 12/08/2016, it was observed on the 2nd floor that the wall separating the Nursing Home from the Assisted Living facility did not have a 2-hour fire separation not in accordance with 19.1.3.3. This deficient practice was verified by the Maintenance Supervisor at the time of inspection.	K 131	This plan of correction constitutes my written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. The plan of correction is submitted to meet the requirements established by State and Federal law. It is the policy of Lake Ridge Care Center to maintain proper fire separation between the nursing home and the assisted living facility. We are in the process of having plans approved to add 90 minute rated doors into the cased opening between the nursing facility and the assisted living facility, that will be tied into the fire alarm	1/30/17

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K 131	Continued From page 3	K 131	system. Because of permitting and plan approvals, we are planning to have the doors installed prior to 30 Jan 2017.	