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: XVYO
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 **07/15/2021** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **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 :
Susie Haben, Unit Supervisor — 08/02/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Melissa Poepping, Enforcement Specialist — 08/02/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **07/23/2021** (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
August 2, 2021

CMS Certification Number (CCN): 245513

Administrator
Lake Ridge Care Center Of Buffalo
310 Lake Boulevard
Buffalo, MN 55313

Dear Administrator:

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

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

Effective July 2, 2021 the above facility is certified for:

56 Skilled Nursing Facility/Nursing Facility Beds

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

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

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically Delivered
August 2, 2021

Administrator
Lake Ridge Care Center Of Buffalo
310 Lake Boulevard
Buffalo, MN 55313

RE: CCN: 245513
Cycle Start Date: June 10, 2021

Dear Administrator:

On July 15, 2021, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

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(L9) **02/01/2004**

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___ 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)

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17. SURVEYOR SIGNATURE Date :
Tina Larsen, HFE NE II 07/06/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 07/23/2021 (L20)

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

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(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
June 25, 2021

Administrator
Lake Ridge Care Center Of Buffalo
310 Lake Boulevard
Buffalo, MN 55313

RE: CCN: 245513
Cycle Start Date: June 10, 2021

Dear Administrator:

On June 10, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by September 10, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 10, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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 ______	C 06/10/2021

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
E 000	Initial Comments On 6/7/21 - 6/10/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 6/7/21 - 6/10/21, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5513027C (MN00068423) H5513028C (MN00062872) H5513029C (MN00063149) H5513030C (MN00046442) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/02/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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
F 000	Continued From page 1 validate that substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess residents for the ability to self-administer medications after nurse setup for 1 of 1 residents (R146) observed self-administering medications. Findings include: R146's Nursing Admission Observation Detail List Report dated 6/3/21, indicated R146 admitted to the facility on 6/3/21 having been alert and orientated to person, place, and time. The admission report identified a heading labeled "Self administration of medications" which questioned if the admitting resident desired to administer their own medications during their stay at the facility. This section lacked a required "No" or "Yes - (if yes, complete self administration of medication observation)" response for R146. R146's Physician Order Report dated 6/9/21, identified a traumatic subdural hemorrhage (bleeding in the brain) as the primary reason for admission and directed staff to administer the following medications: acetaminophen 1000 mg (milligrams) every six hours for right and left sided rib fractures; aspirin 81 mg once a day	F 554	F-554 (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 comprehensively assess residents for the ability to self-administer medications after nurse set-up. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: The cited resident had an observation assessment for the ability to self-administer medications, and a	7/2/21

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F 554	Continued From page 2 (QD) for hypertension (HTN - high blood pressure); Macrobid (antibiotic) 100 mg twice a day (BID) with breakfast and dinner for contusions (injured tissue - bruising) of urinary and pelvic organs; metformin 1500 mg QD with breakfast for diabetes; lisinopril 10 mg QD for HTN; multivitamin 1 tablet QD; senna 1 tablet BID for constipation; Miralax 17 gram/dose QD mixed with 4-8 ounces of liquid for constipation. The report lacked evidence of a self-administration of medication order dated prior to 6/8/21. During continued observation and interview on 6/8/21, at 8:57 a.m. registered nurse (RN-A) prepared R146's eight morning medications as directed by the above Physician Order Report. After, she entered R146's room carrying a medication administration cup with seven of the prepared medications and another plastic cup that contained the prepared Miralax. RN-A placed the medication and Miralax cups on R146's tray table; located directly in front of R146 as she sat in her wheelchair next to her husband. RN-A obtained R146's blood sugar, performed hand hygiene in the bathroom, and exited R146's room before she ensured R146 had taken the medications. At 9:13 a.m. RN-A re-entered R146's room and administered R146's morning insulin. At 9:14 a.m. RN-A exited R146's room in which the cup of Miralax remained unconsumed on the tray table in front of R146. RN-A failed to inquire if R146 had taken her medications and did not remain in R146's room to ensure she consumed the Miralax. - Once returned to the medication cart, RN-A was questioned on R146's having a self-administer of medication order. After RN-A reviewed the electronic medical record (EMR), and before she answered the question, she walked to R146's	F 554	physician order to self-administer medications was obtained on 8 Jun 2021. 2.Actions taken to identify other potential residents having similar occurrences: An audit was conducted of all current residents to verify who has current self-administration orders and who does not. This list was reviewed with all Licensed Staff and TMA's that pass medications, as well as a review of the medication administration policy related to self-administration. 3.Measures put in place to ensure deficient practice does not recur: Facility will add "ok to self-administer (specific medications)" to medication administration area of EMAR. Admissions Coordinator, or their designee, will complete the self-administration portion of the clinical admission assessment, and if the resident desires to self-administer medications, will pass that information on to Unit Manager or designee (floor nurse) to get the observation completed timely. 4.Effective implementation of actions will be monitored by: Director of Nursing, or their designee, will audit all new admissions for completion of the self-administration portion of admission assessment, and observation, physician order completion for 2 weeks. If all are completed correctly, then will move to 50% of admissions for 2 weeks. Director of Nursing, or their designee, will complete medication pass audits to ensure that residents are not left	

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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 554	Continued From page 3 room and asked R146 if she wanted medications left on the table for her and explained she could enter such an order if R146 desired it. R146 acknowledged she wished this. RN-A returned to the cart and started R146's self-administration assessment process in the EMR. RN-A confirmed R146 had not had an order prior to exiting R146's room; however, she stated, "...she does now." RN-A explained she was required to do a self-administration "observation" assessment to determine if a resident was safe to self-administer their medications before medications were left with a resident; however, she denied she would be required to obtain an official physician order for self-administration. RN-A explained if she were to leave medications with a resident she would first need to check to verify the resident had an order to self-administer their medications. RN-A stated, "I automatically know who can self-administer their medication;" however, continued with, "She [R146] is fairly new." In addition, RN-A explained, "...with her [R146] being fairly new, I should have checked to make sure that that [self-administration order] is in place." R146's medical record lacked evidence she had been comprehensively assessed to be safe to self-administer her medications, or an order to do so, after nurse set-up prior to R146 being administered her 6/8/21 morning medications by RN-A. On 6/8/21, at 9:40 a.m. RN-A approached the surveyor and explained she had obtained an official physician order that morning for R146 to self-administer her medications as she had spoken wrong earlier. RN-A stated, "I do need it [official physician order for self-administration]."	F 554	unsupervised with medications. Five med pass audits will be completed the first week, with two audits completed weekly for the next three weeks, followed by two biweekly audits for another four weeks. These audits will be submitted to our next quarterly QAPI meeting to determine the level of continued auditing that might be needed to remain compliant. 5.Those responsible to maintain compliance will be: The Director of Nursing will monitor the self-administration ordering process, along with input from the interdisciplinary team, Admission Coordinator and floor nurses. The Director of Nursing will submit auditing reports to the next quarterly QAPI meeting for compliance review and continuation of auditing. Completion date for certification purposes only is: 2 Jul 2021	

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	245513	A. BUILDING ______ B. WING ______	C 06/10/2021

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F 554	Continued From page 4	F 554		

During interview on 6/8/21, at 9:41 a.m. R146's tray table was observed to be free of the Miralax cup. R146 stated "sometimes" staff leave her unsupervised after setting her up with her medications "but not all the time." R146 had been unable to provide details on prior dates, times, or involved staff who may have left medications with her; however, she did confirm RN-A had left them with her that morning. In addition, R146 confirmed she was in agreement with her being left unsupervised with her medications after setup with a comment of, "...I took them at home and I can take them here by myself."

When interviewed on 6/10/21, at 12:13 p.m. long term care nursing manager (RN-B) stated if a resident desired to self-administer their medications a nurse would be required to perform an "observation" and if the "observation" deemed the resident could safely self-administer their meds they would them obtain an order from the medical provider. Prior to this process, RN-B explained she expected the nurse would "remain within eye sight" of the resident to ensure "something does not happen." RN-B acknowledged R146 should not have had her medications left with her unattended without an order to do so.

A policy Medication Administration, dated 6/2000, directed staff, "Do not leave any medication unless the resident has an order to self administer."

F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		7/2/21

§483.45(g) Labeling of Drugs and Biologicals

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F 761	Continued From page 5 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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 medications were labeled with current and accurate administration instructions to prevent potential medication errors for 1 of 6 residents (R194) observed to receive medication during the survey. Findings include: On 6/7/21, at 5:25 p.m. licensed practical nurse (LPN)-A prepared medications at a mobile cart for R194. LPN-A removed a narcotic bubble medication pack from the cart's locked narcotic	F 761	F-761 (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	

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F 761 Continued From page 6

storage box which had a visible, white colored label affixed to the front corner. The label identified R194's name along with the medication instructions, "HYDROCO/APAP [hydrocodone/acetaminophen (Norco) (opioid pain medication)]] TAB [tablet] 5-325 mg [milligram] C-II 1 - 2 tablets by mouth every 4 hours as needed (1 tab for pain 4-6; 2 tabs for pain 7-10)." The medication bubble pack identified pharmacy attached caution stickers alongside the label; however, the pack lacked evidence of a direction change alert. After preparing the Norco, LPN-A documented the remaining Norco count in the narcotic log book on R194's designated individual narcotic record page. The page identified the same white label as that on the medication bubble pack; however, also lacked any indication of a frequency order change alert. LPN-A did not verbally identify any potential concerns with R194's Norco order before or after she administered two tabs of Norco to R194 in her room.

On 6/9/21, a telephone order (T.O.), dated 5/24/21, identified R194's Norco had a direction change which increased the frequency of administration to every three hours as needed. The T.O. identified LPN-A had obtained the order change and that long term care nursing manager (RN)-B had completed the second nurse order processing check. The T.O. lacked evidence the order had been faxed to the pharmacy.

R194's June 2021 Medication Administration Record (MAR) directed staff to administer the Norco every three hours as needed. The MAR directed order was dated 5/24/21.

During interview on 6/9/21, at 9:31 a.m.

F 761

otherwise identified the same.

It is the policy of Lake Ridge Care Center to ensure medications are labeled with current and accurate administration instructions for those residents receiving medications.

To assure continued compliance, the following plan has been put into place;

1. Regarding cited residents:
The specific issue for this medication was corrected with the proper label with current and accurate administration instructions. All orders and medication cards were reviewed upon her return from the hospital on 11 Jun 2021, and updated cards to reflect any change in orders post-hospitalization.

2.Actions taken to identify other potential residents having similar occurrences:
Other resident medication cards were reviewed, and continue to be reviewed as the nurses are completing their medication passes, to ensure that they are properly labeled with current and accurate administration instructions.

3.Measures put in place to ensure deficient practice does not recur:
We have updated our Telephone and Physician order forms used within the facility to include a sign off checklist at the bottom to ensure proper labeling with current and accurate administration instructions are consistently being properly completed. These forms and

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F 761	Continued From page 7 pharmacist (P)-A stated the pharmacy had on file a physician order for "Norco one to two [tabs] every four hours as needed." P-A stated the original Norco order date had been 5/23/21 and denied the pharmacy computer system identified the Norco order frequency change from 5/24/21. When interviewed on 6/9/21, registered nurse (RN)-C compared R194's Norco order and the Norco bubble medication pack label. After, RN-C verbalized the MAR directed staff to administer the Norco every three hours as needed; however, the medication pack directed every four hours as needed. RN-C acknowledged a direction change sticker should have been placed on the medication pack and on the individual narcotic record page when the frequency order on 5/24/21 had changed. In addition, RN-C examined R194's telephone order's and explained the 5/24/21 T.O. should have had a "stamp" on it that indicated the order was faxed to pharmacy. RN-C confirmed this stamp had not been on the T.O. as per facility practice. RN-C stated a risk factor of staff not being alerted to a potential medication order change would be the resident may receive the wrong medication, the wrong dose, or the medication would be administered at the wrong time. During interview on 6/10/21, at 12:13 p.m. RN-B stated the facility did not have an official policy to apply a direction change sticker on the medication label if an order had changed; however, the facility did have direction change stickers available for staff to use, or staff would use a marker to write an alert on the label. RN-B explained she expected staff to follow the orders as directed on the MAR; however, if there was a discrepancy between the MAR and the	F 761	process were introduced to all licensed staff, HUC and Medical Records staff, as well as Physicians and NP's that frequent our facility. These forms will be implemented 2 Jul 2021. 4.Effective implementation of actions will be monitored by: A review of the medication administration policy, including the use of a direction change sticker, was reviewed with all licensed staff in the facility. Routine monitoring of compliance with this process will be completed by HUC/Medical Records as orders are returned to them after processing for scanning into the electronic medical record. These employees will notify the Director of Nursing, or their designee, if the forms are not being completed appropriately. 5.Those responsible to maintain compliance will be: The HUC/Medical Records will perform daily, routine monitoring of changes to administration instructions. They will report any discrepancies to the Director of Nursing. The Director of Nursing, or their designee, will perform four random audits weekly for two (2) weeks, four random audits biweekly for an additional two (2) weeks and then four random audits monthly for three months. These audit results will be shared at the next two quarterly QAPI committee meetings, to be monitored and reviewed for compliance. Completion date for certification purposes	

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F 761	Continued From page 8 medication label, staff should then review the original physician order(s) in the paper medical record to determine the most current administration direction(s). RN-B confirmed she had not faxed R194's 5/24/21 Norco order to the pharmacy when she had double checked the order on 5/24/21, as she explained she had thought LPN-A "...was going to fax it." RN-B stated the importance of ensuring medications are given as ordered would be so the resident would be free of "complications." A policy Medication Administration, dated 6/2000, indicated a procedure which directed, "Do not change labels on the medication bottles. This may only be done by a pharmacist. It is acceptable, under a nurse's instruction, to place a "Direction Change Refer to Chart" label on a medication where the order has been changed, but current supply is to be used up at the new dose/direction. This is to be done at the time of processing the order change or shortly thereafter."	F 761	only is: 2 Jul 2021	

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
June 25, 2021

Administrator
Lake Ridge Care Center Of Buffalo
310 Lake Boulevard
Buffalo, MN 55313

Re: State Nursing Home Licensing Orders
Event ID: XVYO11

Dear Administrator:

The above facility was surveyed on June 7, 2021 through June 10, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00714	A. BUILDING: ______ B. WING ______	C 06/10/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/7/21 - 6/10/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1	2 000		

these orders and identify the date when they will be completed.

In addition, complaint investigations were also completed at the time of the licensing survey.

The following complaints were found to be UNSUBSTANTIATED:
H5513027C (MN00068423)
H5513028C (MN00062872)
H5513029C (MN00063149)
H5513030C (MN00046442)

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for

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2 000	Continued From page 2 text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess residents for the ability to self-administer medications after nurse setup for 1 of 1 residents (R146) observed self-administering medications. Findings include: R146's Nursing Admission Observation Detail List Report dated 6/3/21, indicated R146 admitted to the facility on 6/3/21 having been alert and orientated to person, place, and time. The	21565	Corrected.	7/2/21

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21565	Continued From page 3 admission report identified a heading labeled "Self administration of medications" which questioned if the admitting resident desired to administer their own medications during their stay at the facility. This section lacked a required "No" or "Yes - (if yes, complete self administration of medication observation)" response for R146. R146's Physician Order Report dated 6/9/21, identified a traumatic subdural hemorrhage (bleeding in the brain) as the primary reason for admission and directed staff to administer the following medications: acetaminophen 1000 mg (milligrams) every six hours for right and left sided rib fractures; aspirin 81 mg once a day (QD) for hypertension (HTN - high blood pressure); Macrobid (antibiotic) 100 mg twice a day (BID) with breakfast and dinner for contusions (injured tissue - bruising) of urinary and pelvic organs; metformin 1500 mg QD with breakfast for diabetes; lisinopril 10 mg QD for HTN; multivitamin 1 tablet QD; senna 1 tablet BID for constipation; Miralax 17 gram/dose QD mixed with 4-8 ounces of liquid for constipation. The report lacked evidence of a self-administration of medication order dated prior to 6/8/21. During continued observation and interview on 6/8/21, at 8:57 a.m. registered nurse (RN-A) prepared R146's eight morning medications as directed by the above Physician Order Report. After, she entered R146's room carrying a medication administration cup with seven of the prepared medications and another plastic cup that contained the prepared Miralax. RN-A placed the medication and Miralax cups on R146's tray table; located directly in front of R146 as she sat in her wheelchair next to her husband. RN-A obtained R146's blood sugar, performed hand hygiene in the bathroom, and exited R146's room	21565		

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21565	Continued From page 4	21565		

before she ensured R146 had taken the medications. At 9:13 a.m. RN-A re-entered R146's room and administered R146's morning insulin. At 9:14 a.m. RN-A exited R146's room in which the cup of Miralax remained unconsumed on the tray table in front of R146. RN-A failed to inquire if R146 had taken her medications and did not remain in R146's room to ensure she consumed the Miralax.

- Once returned to the medication cart, RN-A was questioned on R146's having a self-administer of medication order. After RN-A reviewed the electronic medical record (EMR), and before she answered the question, she walked to R146's room and asked R146 if she wanted medications left on the table for her and explained she could enter such an order if R146 desired it. R146 acknowledged she wished this. RN-A returned to the cart and started R146's self-administration assessment process in the EMR. RN-A confirmed R146 had not had an order prior to exiting R146's room; however, she stated, "...she does now." RN-A explained she was required to do a self-administration "observation" assessment to determine if a resident was safe to self-administer their medications before medications were left with a resident; however, she denied she would be required to obtain an official physician order for self-administration. RN-A explained if she were to leave medications with a resident she would first need to check to verify the resident had an order to self-administer their medications. RN-A stated, "I automatically know who can self-administer their medication;" however, continued with, "She [R146] is fairly new." In addition, RN-A explained, "...with her [R146] being fairly new, I should have checked to make sure that that [self-administration order] is in place."

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Continued From page 5

R146's medical record lacked evidence she had been comprehensively assessed to be safe to self-administer her medications, or an order to do so, after nurse set-up prior to R146 being administered her 6/8/21 morning medications by RN-A.

On 6/8/21, at 9:40 a.m. RN-A approached the surveyor and explained she had obtained an official physician order that morning for R146 to self-administer her medications as she had spoken wrong earlier. RN-A stated, "I do need it [official physician order for self-administration]."

During interview on 6/8/21, at 9:41 a.m. R146's tray table was observed to be free of the Miralax cup. R146 stated "sometimes" staff leave her unsupervised after setting her up with her medications "but not all the time." R146 had been unable to provide details on prior dates, times, or involved staff who may have left medications with her; however, she did confirm RN-A had left them with her that morning. In addition, R146 confirmed she was in agreement with her being left unsupervised with her medications after setup with a comment of, "...I took them at home and I can take them here by myself."

When interviewed on 6/10/21, at 12:13 p.m. long term care nursing manager (RN-B) stated if a resident desired to self-administer their medications a nurse would be required to perform an "observation" and if the "observation" deemed the resident could safely self-administer their meds they would them obtain an order from the medical provider. Prior to this process, RN-B explained she expected the nurse would "remain within eye sight" of the resident to ensure "something does not happen." RN-B acknowledged R146 should not have had her

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21565	Continued From page 6 medications left with her unattended without an order to do so. A policy Medication Administration, dated 6/2000, directed staff, "Do not leave any medication unless the resident has an order to self administer." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by:	21620		7/2/21

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21620	Continued From page 7 Based on observation, interview, and document review, the facility failed to ensure medications were labeled with current and accurate administration instructions to prevent potential medication errors for 1 of 6 residents (R194) observed to receive medication during the survey. Findings include: On 6/7/21, at 5:25 p.m. licensed practical nurse (LPN)-A prepared medications at a mobile cart for R194. LPN-A removed a narcotic bubble medication pack from the cart's locked narcotic storage box which had a visible, white colored label affixed to the front corner. The label identified R194's name along with the medication instructions, "HYDROCO/APAP [hydrocodone/acetaminophen (Norco) (opioid pain medication)]] TAB [tablet] 5-325 mg [milligram] C-II 1 - 2 tablets by mouth every 4 hours as needed (1 tab for pain 4-6; 2 tabs for pain 7-10)." The medication bubble pack identified pharmacy attached caution stickers alongside the label; however, the pack lacked evidence of a direction change alert. After preparing the Norco, LPN-A documented the remaining Norco count in the narcotic log book on R194's designated individual narcotic record page. The page identified the same white label as that on the medication bubble pack; however, also lacked any indication of a frequency order change alert. LPN-A did not verbally identify any potential concerns with R194's Norco order before or after she administered two tabs of Norco to R194 in her room. On 6/9/21, a telephone order (T.O.), dated 5/24/21, identified R194's Norco had a direction change which increased the frequency of administration to every three hours as needed.	21620	Corrected.	

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21620	Continued From page 8 The T.O. identified LPN-A had obtained the order change and that long term care nursing manager (RN)-B had completed the second nurse order processing check. The T.O. lacked evidence the order had been faxed to the pharmacy. R194's June 2021 Medication Administration Record (MAR) directed staff to administer the Norco every three hours as needed. The MAR directed order was dated 5/24/21. During interview on 6/9/21, at 9:31 a.m. pharmacist (P)-A stated the pharmacy had on file a physician order for "Norco one to two [tabs] every four hours as needed." P-A stated the original Norco order date had been 5/23/21 and denied the pharmacy computer system identified the Norco order frequency change from 5/24/21. When interviewed on 6/9/21, registered nurse (RN)-C compared R194's Norco order and the Norco bubble medication pack label. After, RN-C verbalized the MAR directed staff to administer the Norco every three hours as needed; however, the medication pack directed every four hours as needed. RN-C acknowledged a direction change sticker should have been placed on the medication pack and on the individual narcotic record page when the frequency order on 5/24/21 had changed. In addition, RN-C examined R194's telephone order's and explained the 5/24/21 T.O. should have had a "stamp" on it that indicated the order was faxed to pharmacy. RN-C confirmed this stamp had not been on the T.O. as per facility practice. RN-C stated a risk factor of staff not being alerted to a potential medication order change would be the resident may receive the wrong medication, the wrong dose, or the medication would be administered at the wrong time.	21620		

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21620	Continued From page 9 During interview on 6/10/21, at 12:13 p.m. RN-B stated the facility did not have an official policy to apply a direction change sticker on the medication label if an order had changed; however, the facility did have direction change stickers available for staff to use, or staff would use a marker to write an alert on the label. RN-B explained she expected staff to follow the orders as directed on the MAR; however, if there was a discrepancy between the MAR and the medication label, staff should then review the original physician order(s) in the paper medical record to determine the most current administration direction(s). RN-B confirmed she had not faxed R194's 5/24/21 Norco order to the pharmacy when she had double checked the order on 5/24/21, as she explained she had thought LPN-A "...was going to fax it." RN-B stated the importance of ensuring medications are given as ordered would be so the resident would be free of "complications." A policy Medication Administration, dated 6/2000, indicated a procedure which directed, "Do not change labels on the medication bottles. This may only be done by a pharmacist. It is acceptable, under a nurse's instruction, to place a "Direction Change Refer to Chart" label on a medication where the order has been changed, but current supply is to be used up at the new dose/direction. This is to be done at the time of processing the order change or shortly thereafter." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), consulting pharmacist, or designee could review and revise policies and procedures for proper medication labeling following medication order changes. Nursing staff	21620		

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21620	Continued From page 10 could be educated to the importance of labeling medications properly. The DON or designee, along with the pharmacist, could audit medication labeling on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Lake Ridge Care Center of Buffalo was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code (NFPA 99). 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 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/02/2021

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

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K 000	Continued From page 1 STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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 1962 and was determined to be of Type II(111) construction. In 1974, an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The 3rd addition was constructed in 2014, is one-story, is fully fire sprinkler protected and is of Type II(111) construction.	K 000		

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K 000	Continued From page 2 The building is fully sprinkler protected and has a fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 48 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 132 SS=D	Multiple Occupancies - Contiguous Non-Health CFR(s): NFPA 101 Multiple Occupancies - Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than 2-hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 2 - two hour fire separations was found not in compliance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections	K 132	K-132 (D) Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response	6/21/21

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K 132	Continued From page 3 8.2.1.3 and 19.1.3.4. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 10 of 56 residents. Findings include: On 06/10/2021, at 11:15 a.m., during the facility tour it was observed that the cross-corridor doors located in the fire barrier to the Oasis wing did not fully close and latch into the door frame. This deficient condition was verified by a Maintenance Supervisor.	K 132	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 have fire barrier, cross-corridor doors close and latch into the door frame. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: There were no cited residents, but all residents in our Lakeside Oasis unit could be affected. 2.Actions taken to identify other potential residents having similar occurrences: All residents in Lakeside Oasis could be impacted by fire barrier, cross-corridor doors not closing and latching into the door frame. 3.Measures put in place to ensure deficient practice does not recur: Door service company was contacted immediately, and repaired the fire barrier, cross-corridor doors on the Lakeside Oasis unit on 21 Jun 2021. All other cross-corridor doors were assessed to ensure that they all closed and latched into the door frames.	

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K 132	Continued From page 4	K 132	4.Effective implementation of actions will be monitored by: Fire barrier, cross-corridor doors will be inspected monthly, and as needed, for proper function. The Environmental Director will report these monthly inspection results to the next two quarterly QAPI meetings for compliance. 5.Those responsible to maintain compliance will be: The Environmental Director will be responsible for continued routine assessment and reporting results to the facility QAPI committee. Completion date for certification purposes only is: 21 Jun 2021	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of all available documentation, the facility has not maintained the fire alarm system testing and maintenance documentation in accordance with NFPA 101 "The Life Safety Code" 2012 edition	K 345	K-345 (F) 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	7/1/21

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K 345	Continued From page 5 (LSC) section 9.6.1.3, and NFPA 72 National Fire Alarm Code 2010 edition, sections 14.3.1, and 14.6.2. This deficient practice could affect 56 of 56 residents. Findings include: 1) On 06/10/2021, at 10:15 a.m., during the review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor it was revealed that the facility did not conduct a semi-annual visual inspection of the fire alarm initiating devices. 2) On 06/10/2021, at 10:25 a.m. during a review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor, it was revealed that at the time of the inspection the facility had completed the annual fire alarm system testing; but upon further review of the annual fire alarm testing documentation it was found that the inspection report did not contain a detailed list of all the individual initiating devices that had been tested and the results of the testing completed on each individual device. These deficient conditions were verified by the Maintenance Supervisor.	K 345	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 maintain fire alarm system testing and maintenance documentation in accordance with regulations. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: There were no cited residents, but all residents could be affected by fire alarm system testing and maintenance documentation not being complete. 2.Actions taken to identify other potential residents having similar occurrences: All residents could be affected by fire alarm system testing and maintenance documentation not being complete. 3.Measures put in place to ensure deficient practice does not recur: The facility completed a semi-annual inspection of the fire alarm initiating devices on 1 Jul 2021. During the inspection, all fire alarm initiating devices were individually identified and our most recent annual fire alarm system testing was matched up to show that testing had	

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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 345	Continued From page 6	K 345	been completed and the results of each individual device. Our next annual fire alarm system testing will use this updated list to be compliant with this requirement. 4.Effective implementation of actions will be monitored by: The completed semi-annual visual inspection of the fire alarm initiating devices will be provided to the next quarterly QAPI meeting for compliance. 5.Those responsible to maintain compliance will be: The Environmental Director, or their designee, will be responsible for completing the semi-annual visual inspection of the fire alarm initiating devices. Completion date for certification purposes only is: 1 Jul 2021	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 901		7/2/21

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 ______	**06/10/2021**

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K 901	Continued From page 7 Based on staff interview and a review of all available documentation, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient condition could affect 56 of 56 residents. Findings include: On 06/10/2021, at 9:45 a.m. during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility could not provide a completed utility risk assessment document at the time of the inspection. The utility risk assessment that was provided at the time of the inspection did not cover patient care equipment as detailed in NFPA 99 "Health Care Facilities Code" 2012 edition Chapter 10 - Electrical Equipment, and Chapter 11 - Gas Equipment. This deficient condition was verified by a Maintenance Supervisor.	K 901	K-901 (F) 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 have a completed current risk assessment with all required NFPA-99 chapters addressed. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: There were no cited residents, but this deficient condition could affect all residents. 2.Actions taken to identify other potential residents having similar occurrences: All residents could be affected by an incomplete NFPA-99 risk assessment. 3.Measures put in place to ensure deficient practice does not recur: Missing chapters ten (10) and eleven (11) have been added to our NFPA-99 Risk Assessment documentation. Those added areas were evaluated, completed	

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	245513	A. BUILDING **01 - MAIN BUILDING 01** B. WING ___	**06/10/2021**

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K 901	Continued From page 8	K 901	and assessed on 30 Jun 2021. 4.Effective implementation of actions will be monitored by: Our NFPA-99 Risk Assessment is reassessed annually, as part of our Facility Wide Assessment and Emergency Disaster Planning. The completed and updated NFPA-99 Risk Assessment will be provided at our next quarterly QAPI meeting to show compliance. 5.Those responsible to maintain compliance will be: The Environmental Director, or their designee, will be responsible for the completion and annual update of the NFPA-99 Risk Assessment. Completion date for certification purposes only is: 2 Jul 2021	