#### CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Facility ID: 00714

	IANII	- TO BE COMI	TELED DI 1	IIIE SIAI	E SURVET AGENCI	racility ID: 00/14
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245513      2.STATE VENDOR OR MEDICAID NO.		3. NAME AND AI (L3) <b>LAKE RIDG</b> (L4) <b>310 LAKE E</b>	GE CARE CEN		JFFALO	4. TYPE OF ACTION: 2 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW
(L2) <b>066663700</b>		(L5) BUFFALO,	MN		(L6) 55313	5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNER (L9) <b>02/01/2004</b>	RSHIP	7. PROVIDER/SU	JPPLIER CATEGO	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other  8. Full Survey After Complaint
6. DATE OF SURVEY 07/15/202 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 01/31
11LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds  13.Total Certified Beds	<b>56</b> (L18) <b>56</b> (L17)	Complian1.  B. Not in Co	ance With Requirements nee Based On: Acceptable POC compliance with Pro	gram	And/Or Approved Waivers Of Th  2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code  * Code: A*	6. Scope of Services Limit 7. Medical Director
Requirements and/or Applied Wa  14. LTC CERTIFIED BED BREAKDOWN			urvers.	15. FACILITY MEETS	(212)	
18 SNF 18/19 SNF 56	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARKS	(IF APPLICABI	LE SHOW LTC CANC	ELLATION DATI	E):		
17. SURVEYOR SIGNATURE		Date:			18. STATE SURVEY AGENCY A	APPROVAL Date:
Susie Haben, Unit Supervi	sor		08/02/2021	(L19)	Melissa Poepping, Enfo	prement Specialist 08/02/2021 (L20)
PAR	Г II - TO BI	E COMPLETED	BY HCFA R	EGIONAI	OFFICE OR SINGLE ST	ATE AGENCY
DETERMINATION OF ELIGIBILITY      1. Facility is Eligible to Participate 2. Facility is not Eligible	pate (L21)		MPLIANCE WITH IGHTS ACT:	I CIVIL		icial Solvency (HCFA-2572)  I Interest Disclosure Stmt (HCFA-1513) :
22. ORIGINAL DATE 23	. LTC AGREEM	MENT 2	24. LTC AGREE!	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION <b>02/01/1988</b>	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	** - *** - ****************************
		VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
(L27)	B. Rescind Su	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	O. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL I	DATE		
	(L32)	07/23/2021		(L33)	DETERMINATION APPR	OVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

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

Mighing

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

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

Mittig

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

					AND TRANSMITTAL TE SURVEY AGENCY		ID: XVYO Facility ID: 00714
MEDICARE/MEDICAID PROVII     (L1) 245513     2.STATE VENDOR OR MEDICAID     (L2) 066663700		3. NAME AND AD (L3) LAKE RIDO (L4) 310 LAKE B (L5) BUFFALO, L	GE CARE CE BOULEVARD		BUFFALO (L6) 55313	4. TYPE OF ACTI 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) 02/01/2004     6. DATE OF SURVEY 06/18. ACCREDITATION STATUS:	FOWNERSHIP  10/2021 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct	PPLIER CATEC  05 HHA  06 PRTF  07 X-Ray	GORY 09 ESRD 10 NF 11 ICF/IID	02 (L7) 13 PTIP 22 CLIA 14 CORF 0 15 ASC	7. On-Site Visit 8. Full Survey Aft FISCAL YEAR END	<u> </u>
0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	01/31	
11LTC PERIOD OF CERTIFICATION From (a): To (b):  12. Total Facility Beds 13. Total Certified Beds	56 (L18) 56 (L17)	X B. Not in Com	nce With equirements e Based On: cceptable POC	gram	And/Or Approved Waivers O  2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural S 5. Life Safety Code  * Code: B*	el 6. Scope of : 7. Medical I	Services Limit Director oom Size
14. LTC CERTIFIED BED BREAKD 18 SNF 18/19 SNF 56		ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):			
17. SURVEYOR SIGNATURE  Tina Larsen, HFE NE	II	Date :	7/06/2021	(110)	18. STATE SURVEY AGENC		Date: 07/23/2021
PA	ART II - TO BE	COMPLETED F	BY HCFA RI	(L19) EGIONAI	L OFFICE OR SINGLE	STATE AGENCY	(L20
DETERMINATION OF ELIGIB     1. Facility is Eligible to     2. Facility is not Eligible	Participate		IPLIANCE WITI	H CIVIL		nancial Solvency (HCFA-2: trol Interest Disclosure Stn ve :	
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	I. LTC AGREEN	MENT	26. TERMINATION ACTION		(L30)
OF PARTICIPATION <b>02/01/1988</b>	BEGINNING	DATE	ENDING DA	TE	01-Merger, Closure	05-Fail to	JNTARY  o Meet Health/Safety
(L24) 25. LTC EXTENSION DATE:	(L41)  27. ALTERNATI  A. Suspension	VE SANCTIONS of Admissions:	(L25)		02-Dissatisfaction W/ Reimbur 03-Risk of Involuntary Terminat 04-Other Reason for Withdrawa	tion <u>OTHER</u>	o Meet Agreement
(L27)	B. Rescind Su	spension Date:	(L44) (L45)			00-Activ	ve
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)			

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnesotans

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: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm">https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</a>

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: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 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

M. Pais

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 07/06/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL <sup>1</sup> A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
						С
		245513	B. WING			06/10/2021
	PROVIDER OR SUPPLIER  DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIF 310 LAKE BOULEVARD BUFFALO, MN 55313	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00		
	Appendix Z, Emerg Requirements, §48	1, a survey for compliance with ency Preparedness 3.73(b)(6) was conducted ecertification survey. The lliance.				
F 000	signature is not req page of the CMS-29 correction is require	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of of the electronic documents.	F 0	00		
	survey was conductinvestigations were was found to be not requirements of 42	1, a standard recertification ted at your facility. Complaint also conducted. Your facility t in compliance with the CFR 483, Subpart B, ong Term Care Facilities.				
	The following comp UNSUBSTANTIATE H5513027C (MN00 H5513028C (MN00 H5513029C (MN00 H5513030C (MN00	068423) 062872) 063149)				
	as your allegation on Departments accept enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required of first page of the CMS-2567 ic submission of the POC will tion of compliance.				
	onsite revisit of you	acceptable electronic POC, an r facility may be conducted to		TITLE		(X6) DATE

07/02/2021

**Electronically Signed** 

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:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245513	B. WING			, 0/2021
	PROVIDER OR SUPPLIER  DGE CARE CENTER	OF BUFFALO	3	STREET ADDRESS, CITY, STATE, ZIP CODE 810 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	validate that substa	intial compliance with the en attained. in Meds-Clinically Approp	F 000 F 554			7/2/21
	medications if the indefined by §483.21 this practice is clinic. This REQUIREMENT by:  Based on observative review, the facility frassess residents for medications after in (R146) observed set.  Findings include:  R146's Nursing Adr. Report dated 6/3/2 orientated to person admission report id "Self administration questioned if the administer their ow at the facility. This sor "Yes - (if yes, comedication observations of the decidentified a traumate (bleeding in the brain admission and direct following medication (milligrams) every set.	right to self-administer interdisciplinary team, as (b)(2)(ii), has determined that cally appropriate.  NT is not met as evidenced tion, interview, and document ailed to comprehensively or the ability to self-administer urse setup for 1 of 1 residents elf-administering medications.  mission Observation Detail List 1, indicated R146 admitted to 1 having been alert and 1, place, and time. The entified a heading labeled 1 of medications during their stay section lacked a required "No" mplete self administration of ation)" response for R146.  Order Report dated 6/9/21, ic subdural hemorrhage in) as the primary reason for coted staff to administer the 1 ns: acetaminophen 1000 mg six hours for right and left aspirin 81 mg once a day		F-554 (D) Facility timely submits this response plan of correction pursuant to feder state law requirements. This response and plan of correction are not admit or an agreement that a deficiency dexist or that a statement of a deficiency of the state of the facility base it's not to be construed as an admit against interest of the facility, the administrator, of any employees, agor other individuals who participated drafting or who may be discussed of otherwise identified the same.  It is the policy of Lake Ridge Care of the ability to self-administer medical after nurse set-up.  To assure continued compliance, the following plan has been put into plants. The cited resident had an observation assessment for the ability to self-administer medications, and a	al and onse ssions loes ency ed and ssion gents d in the or Center ts for tions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			C <b>10/2021</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10/2021
LAKE DU	DOE OADE OENTED	OF BUFFALO		310 LAKE BOULEVARD		
LAKE RI	DGE CARE CENTER	OF BUFFALO		BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 554	Continued From page	age 2	F 55	4		
	·	sion (HTN - high blood		physician order to self-administ	er	
		id (antibiotic) 100 mg twice a		medications was obtained on 8		
		akfast and dinner for				
		d tissue - bruising) of urinary		2.Actions taken to identify other	potential	
		metformin 1500 mg QD with		residents having similar occurre		
	breakfast for diabe	etes; lisinopril 10 mg QD for		An audit was conducted of all o	urrent	
		1 tablet QD; senna 1 tablet BID		residents to verify who has curi		
		iralax 17 gram/dose QD mixed		self-administration orders and		
		liquid for constipation. The		not. This list was reviewed with		
		ence of a self-administration of		Licensed Staff and TMA's that		
	medication order of	lated prior to 6/8/21.		medications, as well as a review		
	During continued a	phoenyation and interview on		medication administration polic self-administration.	y related to	
		observation and interview on n. registered nurse (RN-A)		sen-auministration.		
		eight morning medications as		3.Measures put in place to ens	ire	
		ove Physician Order Report.		deficient practice does not recu		
		R146's room carrying a		Facility will add "ok to self-adm		
		stration cup with seven of the		(specific medications)" to medi		
		ons and another plastic cup		administration area of EMAR.		
	that contained the	prepared Miralax. RN-A placed		Coordinator, or their designee,	will	
		d Miralax cups on R146's tray		complete the self-administratio		
		ctly in front of R146 as she sat		the clinical admission assessm	•	
		next to her husband. RN-A		the resident desires to self-adn		
		lood sugar, performed hand		medications, will pass that info		
		room, and exited R146's room		to Unit Manager or designee (fl		
		d R146 had taken the		to get the observation complete	a timely.	
		13 a.m. RN-A re-entered		4 Effective implementation of a	otiono will	
		administered R146's morning n. RN-A exited R146's room in		4.Effective implementation of a be monitored by:	SHOLIS WIII	
		liralax remained unconsumed		Director of Nursing, or their des	ianee will	
		front of R146. RN-A failed to		audit all new admissions for co		
		d taken her medications and did		the self-administration portion of		
		6's room to ensure she		admission assessment, and ob		
	consumed the Mira			physician order completion for		
	- Once returned to	the medication cart, RN-A was		all are completed correctly, the		
		16's having a self-administer of		to 50% of admissions for 2 week		
		After RN-A reviewed the		Director of Nursing, or their des		
		record (EMR), and before she		complete medication pass audi		
	answered the ques	stion, she walked to R146's		ensure that residents are not le	ft	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/06/2021 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			UI	<u>NR NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	` ´COMI	SURVEY PLETED
		245513	B. WING			l	C 1 <b>0/2021</b>
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				31	10 LAKE BOULEVARD		
LAKE RII	DGE CARE CENTER	OF BUFFALO			UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 554	room and asked R' left on the table for enter such an order acknowledged she the cart and started assessment proces R146 had not had a	146 if she wanted medications her and explained she could r if R146 desired it. R146 wished this. RN-A returned to I R146's self-administration is in the EMR. RN-A confirmed an order prior to exiting R146's	F 5	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			
	RN-A explained she self-administration determine if a resid their medications be with a resident; how be required to obtain for self-administrati were to leave medication would first need to had an order to self-RN-A stated, "I auto self-administer their continued with, "She addition, RN-A expl being fairly new, I saure that that [self-aplace."	e stated, "she does now." e was required to do a "observation" assessment to ent was safe to self-administer efore medications were left vever, she denied she would in an official physician order on. RN-A explained if she cations with a resident she check to verify the resident f-administer their medications. omatically know who can r medication;" however, e [R146] is fairly new." In ained, "with her [R146] hould have checked to make administration order] is in			level of continued auditing that mighneeded to remain compliant.  5. Those responsible to maintain compliance will be: The Director of Nursing will monitor self-administration ordering process along with input from the interdiscip team, Admission Coordinator and finurses. The Director of Nursing wis submit auditing reports to the next quarterly QAPI meeting for compliant review and continuation of auditing.  Completion date for certification puronly is: 2 Jul 2021	I meeting to determine the ued auditing that might be ain compliant.  Insible to maintain II be: If Nursing will monitor the ation ordering process, at from the interdisciplinary on Coordinator and floor Director of Nursing will greports to the next I meeting for compliance antinuation of auditing.	
	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.						
	surveyor and explain official physician or self-administer her	a.m. RN-A approached the ined she had obtained an der that morning for R146 to medications as she had					

[official physician order for self-administration]."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION  NG	CON	(X3) DATE SURVEY COMPLETED	
		245513	B. WING			C / <b>10/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 310 LAKE BOULEVARD BUFFALO, MN 55313	•	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 554	tray table was obsecup. R146 stated "sunsupervised after medications "but not unable to provide de involved staff who mer; however, she owith her that morning confirmed she was left unsupervised with a comment of, can take them here. When interviewed of term care nursing medications a nursuan "observation" and the resident could suneds they would the medical provider. Pexplained she expensional within eye sight of "something does not acknowledged R14 medications left with order to do so.  A policy Medication directed staff, "Do resident of the staff, "Do resident staff, "Do resid	6/8/21, at 9:41 a.m. R146's rved to be free of the Miralax cometimes" staff leave her setting her up with her of all the time." R146 had been etails on prior dates, times, or may have left medications with did confirm RN-A had left them ng. In addition, R146 in agreement with her being ith her medications after setup "I took them at home and I by myself."  on 6/10/21, at 12:13 p.m. long manager (RN-B) stated if a self-administer their e would be required to perform d if the "observation" deemed afely self-administer their em obtain an order from the rior to this process, RN-B cted the nurse would "remain the resident to ensure	F 5	54		
	administer." Label/Store Drugs a CFR(s): 483.45(g)(l	and Biologicals	F 70	31		7/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP O 310 LAKE BOULEVARD BUFFALO, MN 55313		
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F 761	Drugs and biologicals used in the facility must be		F 76	31		
	professional principal appropriate access	nce with currently accepted ples, and include the sory and cautionary e expiration date when				
	§483.45(h) Storage	e 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.					
	locked, permanent storage of controlled the Comprehensive Control Act of 1976 abuse, except whe package drug distri- quantity stored is in be readily detected	facility must provide separately ly affixed compartments for ed drugs listed in Schedule II of e Drug Abuse Prevention and and other drugs subject to in the facility uses single unit libution systems in which the ininimal and a missing dose can l.  NT 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 (D) Facility timely submits this replan of correction pursuant state law requirements. The and plan of correction are reported or an agreement that a definition of the facilities and plan of construed as a against interest of the facilities administrator, of any emploor other individuals who particularly timely a substituting or who may be discontinuous.	to federal and his response not admissions iciency does a deficiency ally based and an admission ty, the byees, agents rticipated in the	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		245513	B. WING			06/	10/2021
	PROVIDER OR SUPPLIER  DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE  310 LAKE BOULEVARD  BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	storage box which label affixed to the identified R194's na instructions, "HYDF [hydrocodone/aceta pain medication)]] [milligram] C-II 1 - 2 hours as needed (1 pain 7-10)." The modern identified pharmacy alongside the label evidence of a direct preparing the Norce remaining Norce of R194's designated page. The page identified page. The page identified for the medical also lacked any indichange alert. LPN-potential concernsible before or after she Norce to R194 in horce of R194 in horce administration to extend the medical change which increadministration to extend the medical change and that lor (RN)-B had complete processing check. The T.O. identified change and that lor (RN)-B had complete processing check. The T.O. identified change and that lor (RN)-B had complete processing check. The T.O. identified change and that lor (RN)-B had complete processing check. The T.O. identified change and that lor (RN)-B had complete processing check. The T.O. identified change and that lor (RN)-B had complete processing check. The T.O. identified change and that lor (RN)-B had complete processing check. The T.O. identified change and that lor (RN)-B had complete processing check. The T.O. identified change and that lor (RN)-B had complete processing check. The T.O. identified change and that lor (RN)-B had complete processing check. The T.O. identified change and that lor (RN)-B had complete processing check. The T.O. identified change and that lor (RN)-B had complete processing check. The T.O. identified change and that lor (RN)-B had complete processing check. The T.O. identified change and that lor (RN)-B had complete processing check. The T.O. identified change and that lor (RN)-B had complete processing check. The T.O. identified change and that lor (RN)-B had complete processing check. The T.O. identified change and that lor (RN)-B had complete processing check. The T.O. identified change and that lor (RN)-B had complete processing check. The T.O. identified change and the T.O. identified change and the T.O. identifi	had a visible, white colored front corner. The label ame along with the medication ROCO/APAP aminophen (Norco) (opioid TAB [tablet] 5-325 mg 2 tablets by mouth every 4 tab for pain 4-6; 2 tabs for edication bubble pack attached caution stickers however, the pack lacked tion change alert. After o, LPN-A documented the punt in the narcotic log book on individual narcotic record entified the same white label as ion bubble pack; however, ication of a frequency order A did not verbally identify any with R194's Norco order administered two tabs of er room.  One order (T.O.), dated R194's Norco had a direction eased the frequency of very three hours as needed. LPN-A had obtained the order to get term care nursing manager sted the second nurse order The T.O. lacked evidence the ed to the pharmacy.  Medication Administration cours as needed. The MAR	F 7	761	otherwise identified the same.  It is the policy of Lake Ridge Care (to ensure medications are labeled current and accurate administration instructions for those residents recomedications.  To assure continued compliance, the following plan has been put into plant 1. Regarding cited residents:  The specific issue for this medication corrected with the proper label with current and accurate administration instructions. All orders and medicate cards were reviewed upon her return the hospital on 11 Jun 2021, and uput cards to reflect any change in order post-hospitalization.  2. Actions taken to identify other post residents having similar occurrence Other resident medication cards were reviewed, and continue to be review the nurses are completing their medication passes, to ensure that the are properly labeled with current are 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 checklis bottom to ensure proper labeling we current and accurate administration instructions are consistently being	with n eiving ne nce; on was n tion rn from odated rs tential es: ere wed as they id s. nd he t at the ith	
	During interview on	6/9/21, at 9:31 a.m.			properly completed. These forms a	and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		СОМ	(X3) DATE SURVEY COMPLETED	
		245513	B. WING			C 1 <b>0/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
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F 761	pharmacist (P)-A sa physician order for every four hours a original Norco order from the Norco bubble medication pack at the Norco every the medication pack are cord page when had changed. In a telephone order's a should have had a order was faxed to this stamp had not practice. RN-C stabeing alerted to a change would be the twrong medication, medication would time.  During interview or stated the facility of apply a direction comedication label if	age 7 stated the pharmacy had on file for "Norco one to two [tabs] s needed." P-A stated the er date had been 5/23/21 and acy computer system identified equency change from 5/24/21.  on 6/9/21, registered nurse R194's Norco order and the lication pack label. After, RN-C R directed staff to administer ree hours as needed; however, ck directed every four hours as knowledged a direction change e been placed on the nd on the individual narcotic the frequency order on 5/24/21 ddition, RN-C examined R194's and explained the 5/24/21 T.O. I "stamp" on it that indicated the or pharmacy. RN-C confirmed to been on the T.O. as per facility ated a risk factor of staff not potential medication order the resident may receive the the wrong dose, or the be administered at the wrong  n 6/10/21, at 12:13 p.m. RN-B did not have an official policy to hange sticker on the an order had changed; ty did have direction change	F 76		ords staff, as that frequent be  f actions will dministration direction d with all coutine h this ders are ssing for medical ll notify the designee, if pleted tain vill perform hanges to They will he Director of rsing, or their andom audits ur random onal two (2) audits	
	use a marker to we explained she explained she explained she explass directed on the	for staff to use, or staff would rite an alert on the label. RN-B ected staff to follow the orders MAR; however, if there was a seen the MAR and the		results will be shared at the industrial quarterly QAPI committee middle monitored and reviewed for completion date for certification.	eetings, to be compliance.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245513	B. WING			C <b>06/10/2021</b>	
	PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE, ZIP CODE OULEVARD MN 55313	1 00/	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	κ (EA	PROVIDER'S PLAN OF CORRECTION ICH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 761	medication label, st original physician o record to determine administration direct had not faxed R194 pharmacy when shorder on 5/24/21, a thought LPN-A "w stated the important are given as ordere would be free of "co	aff should then review the rder(s) in the paper medical the most current stion(s). RN-B confirmed she less 5/24/21 Norco order to the less had double checked the less she explained she had least going to fax it." RN-B ce of ensuring medications discould be so the resident	F 7		2 Jul 2021		



Protecting, Maintaining and Improving the Health of All Minnesotans

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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 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

PRINTED: 07/06/2021 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00714		B. WING		<b>I</b>	C 1 <b>0/2021</b>
NAME OF	PROVIDER OR SUPPLIER	L	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1	
LAKE RI	DGE CARE CENTER	OF BUFFALO		BOULEVAF ), MN 55313			
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2 000	Initial Comments			2 000			
	****ATTEI	NTION*****					
	NH LICENSING CORRECTION ORDER						
	144A.10, this correspursuant to a surve found that the deficion herein are not correspond to corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation ha	issued tion, it is cited violation ordance rule of s been tag l below. lure to esidered e upon rule will if the item				
	that may result fron orders provided tha the Department wit	hearing on any asse n non-compliance wi it a written request is hin 15 days of receip ent for non-compliance	ith these s made to ot of a				
	conducted at your f Minnesota Departm facility was found no State Licensure and orders are issued. I	rs: , a licensing survey facility by surveyors for nent of Health (MDH) ot in compliance with d the following corrections please indicate in your	rom the ). Your n the MN ction our				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/02/21 **Electronically Signed** 

TITLE

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
	00714			B. WING			C <b>10/2021</b>
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2 000	these orders and ice be completed.  In addition, compla completed at the ting the following completed at the findings (MNO) the findings of the findings which a statute after the statute after	lentify the date when int investigations we me of the licensing solaints were found to ED: 1068423) 1062872) 1063149) 10046442) 10046442) 10046442) 10046442) 10046442) 10046442) 10046442 10046442 10046442 100464442 100464442 100464444 100464444 100464444 10046444 10046444 1004644 1004644 1004644 1004644 10046	cumenting using een ules for nber "ID Prefix npliance is eficiencies" portion of includes e state is not met ors findings on and electronic stent with				

Minnesota Department of Health

STATE FORM 6899 XVYO11 If continuation sheet 2 of 11

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00714	B. WING			D 1 <b>0/2021</b>
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/1	10/2021
	DGE CARE CENTER	310 I AKE	BOULEVAR			
LAKE KI		BUFFALC	), MN 55313			
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2 000	Continued From pa	ge 2	2 000			
	State licensure proc completion date, the corrected prior to el Minnesota Departm					
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREM CORRECTION FO	N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF				
21565	MN Rule 4658.1329 Medications Self Ac	5 Subp. 4 Administration of dmin	21565			7/2/21
	self-administer med resident assessment care as required in 4658.0405 indicate	inistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.				
	by: Based on observati review, the facility fa assess residents fo medications after n	ent is not met as evidenced on, interview, and document ailed to comprehensively or the ability to self-administer urse setup for 1 of 1 residents elf-administering medications.		Corrected.		
	Findings include:					
	Report dated 6/3/21 the facility on 6/3/22	mission Observation Detail List 1, indicated R146 admitted to 1 having been alert and n, place, and time. The				

Minnesota Department of Health

PRINTED: 07/06/2021 FORM APPROVED

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY
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		00714	B. WING		06/1	0/2021
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LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAR , MN 55313	RD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21565	admission report id "Self administration questioned if the adadminister their ow at the facility. This sor "Yes - (if yes, comedication observation observation observation observation observation of identified a traumat (bleeding in the braadmission and direfollowing medicatio (milligrams) every sided rib fractures; (QD) for hypertensipressure); Macrobi day (BID) with breacontusions (injured and pelvic organs; breakfast for diabeth HTN; multivitamin for constipation; Mi with 4-8 ounces of report lacked evide medication order diabeth of the medication administration administration administration and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction her wheelchair necession in the medication and table; located direction and table; located direction her wheelchair nec	lentified a heading labeled of medications" which dmitting resident desired to not medications during their stay section lacked a required "No" implete self administration of ation)" response for R146.  Order Report dated 6/9/21, the subdural hemorrhage with as the primary reason for cted staff to administer the instance and another for tissue - bruising) of urinary metformin 1500 mg QD with tes; lisinopril 10 mg QD for 1 tablet QD; senna 1 tablet BID ralax 17 gram/dose QD mixed liquid for constipation. The ince of a self-administration of ated prior to 6/8/21.  In the servation and interview on a registered nurse (RN-A) ght morning medications as the property of the property of the ince of th	21565			

Minnesota Department of Health

STATE FORM 6899 XVYO11 If continuation sheet 4 of 11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00744			00/4	
	00714			06/1	0/2021
NAME OF PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
LAKE RIDGE CARE CENTER O	OF BUFFALO	BOULEVAR , MN 55313	KD		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
R146's room and ad insulin. At 9:14 a.m. which the cup of Mirson the tray table in frinquire if R146 had to not remain in R146's consumed the Miralator - Once returned to the questioned on R146 medication order. Af electronic medical reanswered the question room and asked R14 left on the table for henter such an order acknowledged she with a cart and started assessment process R146 had not had ar room; however, she RN-A explained she self-administration of determine if a resident their medications be with a resident; however to leave medication were to leave medication would first need to chad an order to self-RN-A stated, "I autor self-administer their continued with, "She addition, RN-A explained fairly new, I she addition, RN-A explained in the self-administer their continued with, "She addition, RN-A explained in the self-administer their continued with, "She addition, RN-A explained in the self-administer their continued with, "She addition, RN-A explained in the self-administer their continued with, "She addition, RN-A explained in the self-administer their continued with, "She addition, RN-A explained in the self-administer their continued with, "She addition, RN-A explained in the self-administer their continued with, "She addition, RN-A explained in the self-administer their continued with, "She addition, RN-A explained in the self-administer their continued with, "She addition, RN-A explained in the self-administer their continued with, "She addition, RN-A explained in the self-administer their continued with, "She addition, RN-A explained in the self-administer their continued with, "She addition, RN-A explained in the self-administer their continued with, "She addition, RN-A explained in the self-administer their continued with, "She addition, RN-A explained in the self-administer their continued with in the self-administer th	R146 had taken the 3 a.m. RN-A re-entered Iministered R146's morning RN-A exited R146's room in alax remained unconsumed ront of R146. RN-A failed to taken her medications and did s room to ensure she	21565			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		SURVEY PLETED
		00714	B. WING			C <b>10/2021</b>
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAK	DDRESS, CITY, ST E BOULEVARI O, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21565	R146's medical red been comprehensis self-administer her so, after nurse set-administered her 6, RN-A.  On 6/8/21, at 9:40 a surveyor and explainted official physician or self-administer her spoken wrong earli [official physician or tray table was obsecup. R146 stated "sunsupervised after medications "but not unable to provide dinvolved staff who with her that morning confirmed she was left unsupervised with a comment of, can take them here.  When interviewed term care nursing resident desired to medications a nurs an "observation" ar the resident could smeds they would the medical provider. Fexplained she expension of the something does not self-administer here.	cord lacked evidence she had vely assessed to be safe to medications, or an order to do up prior to R146 being /8/21 morning medications by /8/21 morning medications by /8/21 morning medications by /8/21 morning for R146 to medications as she had er. RN-A stated, "I do need it refer for self-administration]." /8/8/21, at 9:41 a.m. R146's erved to be free of the Miralax sometimes" staff leave her setting her up with her of all the time." R146 had been etails on prior dates, times, or may have left medications with did confirm RN-A had left them of any line addition, R146 in agreement with her being with her medications after setup with her medications after setup with her medications after setup of the modulation of the medication of the modulation of the modulation of the medication of the modulation of the medication of the modulation of the modulation of the medication of the modulation of the mod				

Minnesota Department of Health

STATE FORM 6899 XVYO11 If continuation sheet 6 of 11

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00714	B. WING		06/1	0/2021
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/1	0/2021
	DGE CARE CENTER	310 I AKI	E BOULEVAF			
		BUFFALC	D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21565	Continued From pa	ge 6	21565			
	medications left wit order to do so.	h her unattended without an				
	directed staff, "Do r	Administration, dated 6/2000, not leave any medication has an order to self				
	director of nursing (review and revise pof medication according practices/procedure educated as necessensuring the reside their own medication or with a change to mental ability to do ensure there is a photo a nurse/medication. The DO any/all resident's modification with a padministration. The					
		R CORRECTION: Twenty-one				
21620	MN Rule 4658.1345	5 Labeling of Drugs	21620			7/2/21
	Drugs used in the n in accordance with	nursing home must be labeled part 6800.6300.				
	This MN Requirements	ent is not met as evidenced				

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  310 LAKE BOULEVARD  BUFFALO, MN 59313  D PROVIDER'S PLAN OF CORRECTION (EACH DEPTICIENCIES) (EACH DEPTICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC DENTIFYING INFORMATION)  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 medications at a mobile cart for R194, LPN-A removed a narcotic bubble medication page Africance in the front corner. The label identified R194's name along with the medication instructions. The front corner. The label identified R194's name along with the medication instructions, "HYDROCO/APAP [hydrocodone/acaetaminophen (Norco) (opioid pain medication)]] TAG [abilet] 5-325 mg [milligram] C-III - 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 (dentified the same white label as that on the medication bubble pack locked 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 (dentified the same white label as that on the medication bubble pack Norco order before or after she administered two tabs of Norco to R194' in her room.		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  LAKE RIDGE CARE CENTER OF BUFFALO  SUMMARY STATEMENT OF EIGENCIENS  (EACH DEFLICIENCY MUST BE PRECEDED BY FILL  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  PREPERLY TAG  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 medications at a mobile cart for R194. LPN-A removed a narcotic bubble medication pack from the cart's tocked 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 [Phydrocodone/acataminophen (Norco) (opioid pain medication)]] TAB [tablet] 5-325 mg [milligram] C-II - 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 alent. 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 alent. LPN-A did not verbally identify any potential concerns with R194's Norco order before or after she administered two tabs of				A. BOILDING.	· <del></del>		,
SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   TAG   SUMMARY STATEMENT OF DEFICIENCIES   TAG   SUMMARY STATEMENT OF DEFICIENCIES   TAG   SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL   TAG   CROSS-REFERENCED TO THE APPROPRIATE   DATE   CROSS-REFERENCED TO THE APPROPRIATE   DATE   CROSS-REFERENCED TO THE APPROPRIATE   DATE   DATE   CROSS-REFERENCED TO THE APPROPRIATE   DATE   DATE			00714	B. WING			
CALL   CALL	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PRÉÉRY TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  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 of a frequency order change alert. LPN-A did not verbally identify any potential concerns with R194's Norco order before or after she administrated two tabs of	LAKE RI	DGE CARE CENTER	OE BLIEFALO				
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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	21620	Continued From pa	nge 7	21620			
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		review, the facility f were labeled with of administration instr medication errors for observed to receive	ailed to ensure medications current and accurate uctions to prevent potential or 1 of 6 residents (R194)		Corrected.		
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		On 6/7/21, at 5:25 (LPN)-A prepared r R194. LPN-A remo medication pack fro storage box which label affixed to the identified R194's na instructions, "HYDF [hydrocodone/aceta pain medication)]] [milligram] C-II 1 - 2 hours as needed (1 pain 7-10)." The maidentified pharmacy alongside the label evidence of a direct preparing the Norce remaining Norco con R194's designated page. The page identified also lacked any indicated change alert. LPN- potential concerns before or after she Norco to R194 in his	medications at a mobile cart for ved a narcotic bubble om the cart's locked narcotic had a visible, white colored front corner. The label ame along with the medication ROCO/APAP aminophen (Norco) (opioid TAB [tablet] 5-325 mg 2 tablets by mouth every 4 1 tab for pain 4-6; 2 tabs for edication bubble pack attached caution stickers; however, the pack lacked tion change alert. After o, LPN-A documented the pount in the narcotic log book on individual narcotic record entified the same white label as tion bubble pack; however, lication of a frequency order A did not verbally identify any with R194's Norco order administered two tabs of er room.				

Minnesota Department of Health

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PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX   (EACH CORRECTIVE ACTION SHOULD BE COMPL		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
LAKE RIDGE CARE CENTER OF BUFFALO  310 LAKE BOULEVARD BUFFALO, MN 55313  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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			00714	B. WING		<b>I</b>	
Summary statement of periclencies   Summary statement of periclencies   ID   PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CACH TAGE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH	NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
SUPFALO, MN 55313   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPILATION OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPROPRIATE DATE OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPROPRIATE DATE	IAKEDI	IDGE CARE CENTER	OF BUEFALO 310 LA	KE BOULEVAR	RD		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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	LAKE KI	IDGE CARE CENTER	BUFFA	LO, MN 55313			
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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	21620	Continued From pa	ge 8	21620			
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	21620	The T.O. identified change and that lor (RN)-B had comple processing check. order had been faxed R194's June 2021 If Record (MAR) directly	LPN-A had obtained the order term care nursing manage ted the second nurse order. The T.O. lacked evidence the ed to the pharmacy.  Medication Administration cted staff to administer the nours as needed. The MAR dated 5/24/21.  6/9/21, at 9:31 a.m. ated the pharmacy had on fine "Norco one to two [tabs] needed." P-A stated the redate had been 5/23/21 and cy computer system identified quency change from 5/24/21.  on 6/9/21, registered nurse R194's Norco order and the cation pack label. After, RN-R directed staff to administer tee hours as needed; however the directed every four hours and the cation pack label. After, RN-R directed every four hours and the cation pack label. After, RN-R directed every four hours and the cation pack label. After, RN-R directed every four hours and the individual narcotic he frequency order on 5/24/24 dition, RN-C examined R194 and explained the 5/24/21 T.C "stamp" on it that indicated the pharmacy. RN-C confirmed been on the T.O. as per facilied a risk factor of staff not otential medication order he resident may receive the the wrong dose, or the	er er e d d			

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Minnesota Department of Health STATE FORM

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00714	B. WING		06/1	0/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAR , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	During interview on stated the facility di apply a direction che medication label if a however, the facility stickers available for use a marker to write explained she expenses directed on the I discrepancy between medication label, storiginal physician or record to determine administration directed anot faxed R194 pharmacy when shorder on 5/24/21, at thought LPN-A " who stated the important are given as ordered would be free of "control of the proceduction of the proceduction of the proceduction of the proceduction of the processing the order than the processing the processi	age 9  1 6/10/21, at 12:13 p.m. RN-B d not have an official policy to range sticker on the an order had changed; y did have direction change or staff to use, or staff would ite an alert on the label. RN-B rected staff to follow the orders MAR; however, if there was a ren the MAR and the raff should then review the rafer(s) in the paper medical enter the most current ction(s). RN-B confirmed she had double checked the she explained she had was going to fax it." RN-B are of ensuring medications and would be so the resident	21620		INAL	
	or designee could r procedures for prop	review and revise policies and per medication labeling n order changes. Nursing staff				

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE :	
			7 20.25 10.			;
		00714	B. WING		1	0/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	()F BUFFAL()	BOULEVAR , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21620	Continued From pa	ge 10	21620			
	medications proper along with the phare	to the importance of labeling ly. The DON or designee, macist, could audit medication ar basis to ensure compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				

6899

Minnesota Department of Health STATE FORM

PRINTED: 07/07/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245513	B. WING	i		06/	10/2021
	PROVIDER OR SUPPLIER  DGE CARE CENTER	OF BUFFALO		3	STREET ADDRESS, CITY, STATE, ZIP CODE B10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICIENCY)	) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	K	000			
	FIRE SAFETY						
	Minnesota Departn time of this survey, Buffalo was found requirements for pa Medicare/Medicaid 483.70(a), Life Safo of National Fire Pro Standard 101, Life 19 Existing Health	Survey was conducted by the nent of Public Safety. At the Lake Ridge Care Center of not in compliance with the articipation in at 42 CFR, Subpart ety from Fire, the 2012 edition of safety Code (LSC), Chapter Care and the 2012 edition of icilities Code (NFPA 99).					
	ALLEGATION OF ODEPARTMENT'S ASSIGNATURE AT THE	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS F COMPLIANCE.					
	ONSITE REVISIT OF CONDUCTED TO SUBSTANTIAL COREGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
		E AN EPOC, A PAPER COPY CORRECTION IS NOT					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY					
	HEALTH CARE FII			_			
ABORATOR'	/ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGI	VATURE		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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245513 B. WING 06/10/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD LAKE RIDGE CARE CENTER OF BUFFALO BUFFALO, MN 55313 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 000 | Continued From page 1 K 000 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.

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