MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Buffalo Lake Health Care Center	**Report Number:** H5589006	**Date of Visit:** October 23, 2017
Facility Address: 703 West Yellowstone Trail	**Time of Visit:** 9:45 a.m. to 5:30 p.m.	**Date Concluded:** February 9, 2018
Facility City: Buffalo Lake	**Investigator's Name and Title:** Arthur Biah, RN, Special Investigator	
State: Minnesota	**ZIP:** 55314	**County:** Renville

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was emotionally abused when a facility staff/alleged perpetrator put a crown and a sash on the resident while in the bathroom called the resident, the "King of the Throne".

- ☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on preponderance of evidence, abuse occurred when the alleged perpetrator (AP) put a crown on the head and a sash across the chest of a resident, placed him/her on the toilet, calling him/her "King of the Throne" both during and after toileting.

The resident was admitted to the facility with diagnoses of dementia, stroke, right-sided weakness, and aphasia (loss of ability to understand or express speech). The resident required assistance with toileting, dressing, and had difficulty in communicating needs to staff. The resident's brief interview of mental status score was 2 out of 15, indicating severe cognitive impairment.

On the day of the incident, a witness observed the AP assistthe resident with incontinence care by bringing the resident to the bathroom. While in the bathroom, the AP placed a crown on the resident's head and a sash across of the chest while s/he was sitting on the toilet. The AP referred to the resident as the "King of the Throne". After the AP provided incontinent care the AP sat the resident in his/her wheelchair and placed the resident in the hallway. The witness reported the incident to a nurse and social worker.

The social worker immediately reported the incident's to the facility's director of nursing and administrator.

The AP was interviewed and stated s/he she placed the crown on the resident's head. S/he stated she did not place the sash on the resident. The AP stated another staff placed the sash. The AP acknowledged s/he was trained on vulnerable adult abuse prevention. Review of the AP's personnel file did not indicate any previous discipline for abuse of resident.

During an interview with staff, s/he denied being in the bathroom with the AP and did not place the sash on the resident.

The resident's family member was interviewed and stated the nursing assistant's treatment of the resident made him/her look stupid. The family member stated s/he did not think it was appropriate for the staff to make fun of and laugh at the resident.

During an interview, the director of nursing stated the AP was suspended and then terminated after the abuse investigation.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☒ Abuse ☐ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☐ Facility is responsible for the

☒ Abuse ☐ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility provided the AP training in vulnerable adult prevention, but AP did not follow facility's policy on abuse prevention as trained.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Nurses Notes
- [x] Assessments
- [x] Care Plan Records
- [x] Facility Incident Reports

Other pertinent medical records:

Additional facility records:

- [x] Resident/Family Council Minutes
- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Four

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) ○ Yes ○ No ◉ N/A

Specify: Facility self report.

If unable to contact reporter, attempts were made on:

Date: Time: Date: Time: Date: Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify:

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify:

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Five

Interview with staff: ◉ Yes ○ No ○ N/A Specify:

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Eight

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify:

Attempts to contact:

Date: Time: Date: Time: Date: Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify

Observations were conducted related to:

☒ Nursing Services

☒ Call Light

☒ Cleanliness

☒ Dignity/Privacy Issues

☒ Facility Tour

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify:

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Buffalo Lake Police Department

Renville County Attorney

Buffalo Lake City Attorney

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	C 12/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5589006. As a result, the following deficiency is issued. 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. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 223 SS=G	FREE FROM ABUSE/INVOLUNTARY SECLUSION CFR(s): 483.12(a)(1) 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to prevent the abuse of a resident for one of five residents, (R1), reviewed for abuse. R1 was harmed when R1 was sitting on the toilet, staff put a crown on his head, a sash across his body, and called R1 "King of the Throne" during and after toileting. Findings include: R1's medical record was reviewed. R1 admitted	F 223		

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

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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F 223	Continued From page 1 to the facility with diagnoses of dementia, stroke, and aphasia for long term care. R1 had severe cognitive impairment and required staff assistance for toileting, transfers, and dressing. R1 had difficulty with communication and would not always respond verbally to staff. R1's Brief Interview for Mental Status (BIMS) score was 2 out of 15, indicating severe cognitive impairment. In an undated investigation note, the administrator and social worker (SW)-I interviewed nursing assistant (NA)-H on October 12, 2017 at 11:00 a.m. During the interview, NA-H stated she put a sash on R1 while nursing assistant (NA)-G placed the crown on R1 and called R1 the "King of the Throne". NA-H stated her action might be taken as derogatory to R1 by others. During an interview on October 23, 2017 at 2:23 p.m., the registered nurse (RN)-B stated NA-H called her to assess rash on R1's leg while R1 was in his bathroom. RN-B stated when she came in, she saw R1 sitting on the toilet with a crown on his head and a sash across his body. RN-B stated she asked the NA-H what was going on and NA-H stated R1 was a king on his throne. RN-B stated she left the bathroom after assessing the rash. RN-B stated she did not asked NA-H to remove the crown and sash, nor report the incident of alleged mistreatment to her supervisor. During interview on October 23, 2017 at 3:14 p.m., the director of nursing stated she received a call from the facility that NA-H had R1 in bathroom on the toilet and had a crown and sash on R1's head and around the body. The director of nursing stated she was told NA-H called R1 a	F 223		

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F 223	Continued From page 2 "King of the Throne" while he was sitting on the toilet in the bathroom with a crown and sash. The director of nursing stated NA-H was suspended and later terminated after investigation because of pattern of inappropriate behaviors with residents including telling family member she did not have time for assisting a resident and not working with other staffs to care for residents. The director of nursing stated no staff education or training occurred after the incident. During interview on October 30, 2017 at 12:24 p.m., family member (FM)-F stated she asked NA-H to assist R1 with incontinence care. FM-F stated NA-H placed a crown on R1's head and a sash across his body while R1 was sitting on the toilet. After toileting R1, NA-H left the crown and sash on R1, placed him in the wheelchair, and put R1 in the hallway. FM-F stated R1 would have been offended if he was aware of the treatment by the staff. During an interview on October 30, 2017 at 1:35 p.m., NA-G and stated she saw the NA-H placed crown and sash while R1 was sitting on the toilet in the bathroom. NA-G stated she was replacing R1's drinking water when she NA-H assisting R1 with toileting in R1's bathroom. NA-G stated she saw R1 forty-five minutes later and R1 was still wearing the crown and sash in the hallway. NA-G stated the crown and sash was not R1's usual attire. NA-G stated she did not assist NA-H with R1's care or place a sash on him. NA-G stated she was not in the bathroom and had only seen the incident when she was replacing R1's water. The NA-H was interviewed on November 1, 2017 at 3:42 p.m. and stated she placed sash on R1's body prior to putting him on the commode. NA-H	F 223		

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F 223	Continued From page 3 stated NA-G was assisting her and had placed the crown on R1's head before NA-H put the sash on. NA-H stated she called RN-B to assess R1's rash and RN-B saw the crown and sash. NA-H stated the crown and sash remained on R1 when she placed him back in the wheelchair and when he sat in the hallway. NA-H stated she was joking when she placed the crown on R1, and did not mean to mistreat R1. In an interview on November 2, 2017 at 2:20 p.m. SW-I stated FM-F reported the incident to her that NA-H placed crown and sash on R1. SW-I stated RN-B and LPN-E were aware of the crown and sash on R1, but did not intervene. The family member (FM)-J was interviewed and stated the NA-H's treatment of R1 was inappropriate and demeaning. The facility's policy and procedure titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property and reviewed May 2017 indicated the facility will ensure residents are free from abuse.	F 223		

Minnesota Department of Health

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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: A complaint investigation was conducted to investigate complaint #H5589006. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at	2 000		

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2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interviews and record review, the facility failed to prevent the maltreatment of a resident for one of five residents, (R1), reviewed for abuse. R1 was harmed when R1 was sitting	21850		

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21850	Continued From page 2 on the toilet, staff put a crown on his head, a sash across his body, and called R1 "King of the Throne" during and after toileting. Findings include: The facility's policy and procedure titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property and reviewed May 2017 indicated the facility will ensure residents are free from abuse. R1's medical record was reviewed. R1 admitted to the facility with diagnoses of dementia, stroke, and aphasia for long term care. R1 had severe cognitive impairment and required staff assistance for toileting, transfers, and dressing. R1 had difficulty with communication and would not always respond verbally to staff. R1's Brief Interview for Mental Status (BIMS) score was 2 out of 15, indicating severe cognitive impairment. In an undated investigation note, the administrator and social worker (SW)-I interviewed nursing assistant (NA)-H on October 12, 2017 at 11:00 a.m. During the interview, NA-H stated she put a sash on R1 while nursing assistant (NA)-G placed the crown on R1 and called R1 the "King of the Throne". NA-H stated her action might be taken as derogatory to R1 by others. During an interview on October 23, 2017 at 2:23 p.m., the registered nurse (RN)-B stated NA-H called her to assess rash on R1's leg while R1 was in his bathroom. RN-B stated when she came in, she saw R1 sitting on the toilet with a crown on his head and a sash across his body. RN-B stated she asked the NA-H what was going on and NA-H stated R1 was a king on his throne.	21850		

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21850	Continued From page 3 RN-B stated she left the bathroom after assessing the rash. RN-B stated she did not asked NA-H to remove the crown and sash, nor report the incident of alleged mistreatment to her supervisor. During interview on October 23, 2017 at 3:14 p.m., the director of nursing stated she received a call from the facility that NA-H had R1 in bathroom on the toilet and had a crown and sash on R1's head and around the body. The director of nursing stated she was told NA-H called R1 a "King of the Throne" while he was sitting on the toilet in the bathroom with a crown and sash. The director of nursing stated NA-H was suspended and later terminated after investigation because of pattern of inappropriate behaviors with residents including telling family member she did not have time for assisting a resident and not working with other staffs to care for residents. The director of nursing stated no staff education or training occurred after the incident. During interview on October 30, 2017 at 12:24 p.m., family member (FM)-F stated she asked NA-H to assist R1 with incontinence care. FM-F stated NA-H placed a crown on R1's head and a sash across his body while R1 was sitting on the toilet. After toileting R1, NA-H left the crown and sash on R1, placed him in the wheelchair, and put R1 in the hallway. FM-F stated R1 would have been offended if he was aware of the treatment by the staff. During an interview on October 30, 2017 at 1:35 p.m., NA-G and stated she saw the NA-H placed crown and sash while R1 was sitting on the toilet in the bathroom. NA-G stated she was replacing R1's drinking water when she NA-H assisting R1 with toileting in R1's bathroom. NA-G stated she	21850		

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21850	Continued From page 4 saw R1 forty-five minutes later and R1 was still wearing the crown and sash in the hallway. NA-G stated the crown and sash was not R1's usual attire. NA-G stated she did not assist NA-H with R1's care or place a sash on him. NA-G stated she was not in the bathroom and had only seen the incident when she was replacing R1's water. The NA-H was interviewed on November 1, 2017 at 3:42 p.m. and stated she placed sash on R1's body prior to putting him on the commode. NA-H stated NA-G was assisting her and had placed the crown on R1's head before NA-H put the sash on. NA-H stated she called RN-B to assess R1's rash and RN-B saw the crown and sash. NA-H stated the crown and sash remained on R1 when she placed him back in the wheelchair and when he sat in the hallway. NA-H stated she was joking when she placed the crown on R1, and did not mean to mistreat R1. In an interview on November 2, 2017 at 2:20 p.m. SW-I stated FM-F reported the incident to her that NA-H placed crown and sash on R1. SW-I stated RN-B and LPN-E were aware of the crown and sash on R1, but did not intervene. The family member (FM)-J was interviewed and stated the NA-H's treatment of R1 was inappropriate and demeaning. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21850		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245589	A. BUILDING _____ B. WING _____	R-C 03/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Post Certification revisit was conducted on March 6, 2018, to follow up on deficiencies issued relate to complaint H5589006. Buffalo Lake Health Care Center is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. 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.	{F 000}		

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

Electronically Signed | 03/20/2018

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.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00550	A. BUILDING: _____ B. WING _____	R-C 03/06/2018

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

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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: A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5589006. Buffalo Lake Health Care Center was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first	{2 000}		

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

Electronically Signed | 03/20/18

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00550	A. BUILDING: _____ B. WING _____	R-C 03/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Continued From page 1 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.	{2 000}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 14, 2018

Mr. Mark Rust, Administrator
Buffalo Lake Health Care Center
703 West Yellowstone Trail, PO 368
Buffalo Lake, MN 55314

Re: Enclosed Reinspection Results - Complaint Number H5589006

Dear Mr. Rust:

On March 6, 2018 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on December 27, 2017. At this time these correction orders were found corrected.

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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

March 14, 2018

Mr. Mark Rust, Administrator
Buffalo Lake Health Care Center
703 West Yellowstone Trail, PO 368
Buffalo Lake, MN 55314

RE: Project Number H5589006

Dear Mr. Rust:

On January 3, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by the Office of Health Facility Complaints for an abbreviated standard survey completed on December 27, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On January 3, 2018, we informed you that the following enforcement remedy was being imposed:

- State monitoring, effective January 8, 2018. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil monetary penalty for the deficiency cited at F223. (42 CFR 488.430 through 488.444)

On March 2, 2018, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 27, 2018. (42 CFR 488.417 (b))

Also, we notified you in our letter of March 2, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 27, 2017.

This was based on the deficiencies cited by the Office of Health Facility Complaints for an abbreviated standard survey completed on December 27, 2017, and lack of verification of substantial compliance with the health deficiencies at the time of our March 2, 2018 notice. The most serious health deficiencies in your facility at the time of the abbreviated standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On March 6, 2018, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on December 27, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 21, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on December 27, 2017, as of February 21, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state

monitoring effective February 21, 2018.

Also, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letters from December 27, 2017 and March 2, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 27, 2018, be rescinded. (42 CFR 488.417 (b))

- Civil Money Penalty for the deficiency cited at F223, be imposed. (42 CFR 488.430 through 488.444)

In our letter of March 2, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 27, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 21, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 27, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 27, 2018, is to be rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
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