DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 16, 2022

Administrator
Buffalo Lake Health Care Ctr
703 West Yellowstone Trail, PO 368
Buffalo Lake, MN 55314

RE: CCN: 245589
Cycle Start Date: January 13, 2022

Dear Administrator:

On February 9, 2022, the Minnesota Department of Health 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 25, 2022

Administrator
Buffalo Lake Health Care Ctr
703 West Yellowstone Trail, PO 368
Buffalo Lake, MN 55314

Re: Event ID: 56D911

Dear Administrator:

The above facility survey was completed on January 13, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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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 01/13/2022

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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F 000	INITIAL COMMENTS On 1/12/22 through 1/13/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5589013C (MN79977) with no deficiency issued. The following complaint was found to be UNSUBSTANTIATED: H5589014C (MN79993) As a result of the investigation a deficiency was cited at F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged	F 610		1/31/22

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

Electronically Signed | 01/31/2022

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 610	Continued From page 1 violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of potential physical abuse were thoroughly investigated to ensure resident protection by immediately removing the alleged perpetrator (AP) following an abuse allegation and resident interviews were conducted for 1 of 1 allegation of abuse.. This had the potential to affect all nine residents who were currently residing on the North wing under the AP's care. Findings include: R1's quarterly Minimal Data Set (MDS) dated 11/15/21, indicated R1 had diagnoses which included dementia, psychotic disorder and anxiety disorder. Further review of MDS, indicated R1 exhibited physical and verbal behaviors. Review of facility report number 345656 made to the State Agency (SA) on 1/6/22, alleged R1 was combative and attempting to bite trained medication aide (TMA)-A and nursing assistant (NA)-A while the staff were assisting R1 with	F 610	It is the intent of the Buffalo Lake Healthcare Center to have evidence that all alleged violations are thoroughly investigated, prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. The resident involved in the initial vulnerable adult report is not able to be interviewed. Other residents that receive care from the alleged perpetrator have since been interviewed and no concerns of abuse identified. Education has been completed for all licensed staff and staff that are responsible for submission and investigation of vulnerable adult reports. The facility policy has been updated to reflect the need to interview other residents during and vulnerable adult investigation and immediately remove the alleged perpetrator pending the	

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F 610	Continued From page 2 evening cares. NA-A "took resident's [R1] own hand and put it in resident's mouth and commented 'how does that taste [R1]?'" Review of the five-day investigation submitted to the SA dated 1/11/22, indicated NA-A denied allegation. Further review of investigation indicated the director of nursing (DON) interviewed other staff following the allegation and there were no concerns reported regarding NA-A, however investigation lacked evidence other residents under the care of NA-A were interviewed to determine if there were additional concerns for abuse or care. In addition, NA-A was put on a suspension during the internal investigation, but investigation lacked evidence that NA-A was immediately removed from the care of residents after the physical abuse allegation was made on 1/6/22. Review of facility's schedule for the nursing department dated 1/6/22, indicated NA-A was scheduled to work from 2:00 p.m. until 9:30 p.m. On 1/12/22, at 3:09 p.m. licensed practical nurse (LPN)-A indicated she was the floor nurse on 1/6/22, the evening the allegation was made. LPN-A indicated TMA-A reported NA-A had taken R1's hand and put it in R1's mouth when R1 was attempting to bite NA-A and said "something about how does that taste" which occurred "around 8:00 p.m." LPN-A indicated she immediately called the DON following the allegation, and the DON directed LPN-A to file a report to the SA. Further, when asked how R1 and other residents under the care of NA-A were protected after the allegation was made, LPN-A stated "I didn't do anything with [NA-A]. I knew it was the end of the day and I think she had a bath	F 610	investigation. All vulnerable adult reports will be reviewed by the Administrator/Director of Nursing/Designee immediately. The facility will follow the policy and remove anyone that is suspected of abuse from resident care pending the results of a thorough investigation. Any vulnerable adult reports will be brought to the QA team for review and further guidance as needed.	

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F 610	Continued From page 3	F 610		

yet to do. She finished her shift. I was not given direction on needing to do anything with [NA-A] and I usually don't have anything to do with that. I take the direction of the DON" and LPN-A confirmed the DON did not give direction on removing NA-A from the facility. In addition, LPN-A indicated she assessed R1's skin following the allegation and "she did have a couple of bruises on her right hand. I did ask [TMA-A] about it and we couldn't verify if they [bruising] were there prior or occurred with the incident."

On 1/12/22, at 3:36 p.m. TMA-A indicated he was assisting R1 in the bathroom with her evening cares when NA-A entered the room. TMA-A told NA-A he would finish assisting R1 with her evening cares and NA-A could assist other residents. NA-A refused to leave and R1 became upset and "started hitting, kicking, and biting [NA-A]. [NA-A] was kind of shouting at her [R1] to stop and other random things. [NA-A] was grabbing [R1]'s hands and took her hands and stuck it in her mouth and said 'how does that taste [R1]?' I told NA-A she needs to leave." Further, TMA-A indicated R1's "eyes seemed glossed, confused and seemed like there was pain" following the incident. In addition, TMA-A indicated he reported the incident to LPN-A and "I was freaking out because I was scared. It was an incident that shouldn't have happened." TMA-A indicated after the allegation was reported, [NA-A] still worked with other residents as her shift was not finished until 9:30 p.m.

On 1/13/22, at 9:03 a.m. DON indicated R1 exhibited kicking, hitting, and biting behaviors that often occurred "all of a sudden". Further, DON indicated she was notified of the abuse allegation on 1/6/22, at 8:04 p.m. when LPN-A called her.

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F 610	Continued From page 4	F 610		

DON indicated it was reported to her that TMA-A "was upset. He had been providing care for [R1] and [NA-A] came in and [R1] became agitated and trying to bite them and [NA-A] brought [R1]'s hand to her mouth and commented 'how does that taste [R1]?'" When asked what the staff did to protect the residents following the allegation, DON indicated NA-A was removed "from the situation, she was still in the building, it was around 8:00 p.m. and she was due to leave by 9:30 p.m." When asked what the facility's process was for removing an employee following an allegation, DON indicated the alleged perpetrator was to be removed "as soon as possible", and LPN-A had asked the DON on the phone that evening if she needed to remove NA-A and DON stated "LPN-A hadn't checked for bruising yes she was trying to determine if she needed to remove her or not. I checked the schedule, and she was not scheduled to work over the weekend. We determined a 3-day suspension and based on [NA-A]'s overall work performance she hasn't ever been a person in an abuse situation, but we didn't know that at the time, so we did not immediately remove her from the building I was more worried about trying to make sure we got the report filed and begin the investigation." Further, while referencing the facility's abuse policy, DON stated, "according to the policy they contact administration for help or guidance if it's a situation they feel they need to remove them they can remove them immediately. I feel like it was a he said she said situation. She said she didn't bring it to her mouth. I don't know if [LPN-A] talked to [NA-A] that night." In addition, when asked the importance of removing the AP from the building following an abuse allegation, DON stated, "I don't think it would have protected others in this situation. I really think you are

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F 610	Continued From page 5	F 610		

putting others at risk being there is no one to care for them if I removed her and no there is no one to put others to bed. [TMA-A] has a rapport with [R1] that is beyond anyone and [NA-A] was not taking care of anyone on the wing with those behaviors so removing her from [R1] was our main priority." DON indicated during the investigation following the allegation she interviewed other staff members which showed no concerns regarding NA-A, however DON stated, "I did not interview other residents at all because of the timing of the whole incident. I was three hours up north, [Administrator] was gone, [Social Worker] was gone. Typically, me and the [Social Worker] do all interviews together depending on the situation we interview residents." In addition, DON indicated interviewing residents during the investigation would be important "to make sure there is nothing going on behind closed doors that you don't know about."

On 1/13/22, at 11:34 a.m. when asked what the facility's policy is for removing an AP once an allegation was made, administrator stated, "it would depend on the situation that occurred. We are removing them from the situation that occurred, the alleged situation. It depends its not a hard and fast rule there is a charge nurse in the building, and they have judgment if they need to leave the building right away." Further, administrator indicated it was important to remove the AP until "we can determine what actually happened." When asked how the staff protect other residents following an allegation of a staff member, administrator stated "the charge nurse is expected to keep the other residents out of danger." In addition, administrator indicated interviewing other residents following an abuse

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F 610	Continued From page 6	F 610		

allegation "can be part of the process, but it's not a requirement." When asked why it would be important to interview other residents, administrator was unable to give answer but stated, it would be important" and "depends on the situation".

Review of facility policy titled Freedom from Abuse, Neglect, and Exploitation Policy and Procedure dated 6/14/21, indicated "it is the policy of this facility that the resident (s) will be protected from the alleged offender(s), physical and psychosocial harm during and after the investigation." Further, "safety, security, and support of the resident, their roommate, if applicable and other residents with the potential to be affected will be provided. This should include as appropriate: the alleged perpetrator will immediately be removed, and resident protected. Employee's accused of alleged abuse will be immediately removed from the resident's area and will remain removed pending the results of a thorough investigation." In addition, policy lacked procedure of interviewing other residents following an abuse allegation as part of a thorough investigation.

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 1/12/22 through 1/13/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.

The following complaint was found to be

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2 000	Continued From page 1 SUBSTANTIATED: H5589013C (MN79977), however NO licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H5589014C (MN79993) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		