

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Lake Ridge Care Center of Buffalo, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 310 Lake Boulevard Buffalo, MN 55313	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20794 Based on interview and document review, the facility failed to ensure a level II preadmission screening and resident review (PASARR) was completed for 1 of 1 residents (R35) residents reviewed with a diagnosis of Mild intellectual Disability. Findings include: R35's Annual Minimum Data Set (MDS), dated [DATE]; indicated R35 had diagnosis of anxiety disorder. In review of R35's History and Physical, dated [DATE], diagnoses also included obsessive compulsive disorder (OCD) and Adjustment disorder with anxious mood. R35's admitted was [DATE]. In review of R35' level I PASARR was completed on [DATE] prior to admission and indicated a PASARR level II was required before R35 admitted to a nursing facility. Form also indicated the presence of a developmental disability. In review of R35's Level II PASARR (dated [DATE]) indicated the diagnosis of Mild Intellectual Disability. The anticipated length of stay: ,d+[DATE] days. In further review of R35's level II PASARR, under Final Determination of Length of Stay, The screener completing this form marked the following: The person has developmental disabilities or related conditions and meets one of the following conditions (if yes, pick one of next four options): > As determined by the physician, this person requires recuperative care for physical illness or surgery for the hospitalization was required within the past two weeks. This person does require nursing facility (NF) services and will be admitted to the NF for a time limited stay of 150 days or less. > This person has a terminal illness and/or requires hospice services. Based on signed statements from the physician, this person's life expectancy is six months or less. This person does require NF services and will be admitted to the NF for long-term care. > This person requires a NF stay of fewer than 30 days and the person is expected to return to the community following the brief NF stay. This person requires NF services and will be admitted to the NF. (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 245513	Facility ID: 245513 If continuation sheet Page 1 of 14

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	> This person had ongoing medical and health needs and requires NF services. This person will be admitted to the NF for a stay of 151 days or more. Of the four options given none of them were marked as the reason for admission. The Level II PASARR indicated Anticipated discharge date of [DATE]. In further review of R35's medical record, a second Level I PASARR had been completed on [DATE]. Both Level 1 PASARRs were accompanied by a Level II. Both Level IIs were dark and illegible, being unable to determine if R35 required any services, the nursing home could not provide. An attached email documented R35 had Department of Human Services (DHS) approval R35's continued long term care stay only through [DATE]. In interview on [DATE] at 10:16 a.m., R35 stated he had been living in a group home in Otsego before coming here. He was unaware of why he was in this facility, only that this was where he was to now live. During multiple survey observations, from [DATE] - [DATE], R35 was observed independently attending facility activities and meals with verbal cueing, laying on his bed watching TV, and walking around the central dayroom / entrance area people watching. On [DATE] at 3:25 p.m., attempt was made to contact by phone the [NAME] County social worker (COLSW) who had completed all of R35's PASARRs. A voice message was left with a call back number. No call back had been received during the duration of the survey. During a telephone interview on [DATE] at 7:43 a.m., R35's family member (FAM)-A stated R35 had been in multiple group homes since his mother died . During the last group home stay, the facility was not monitoring R35's blood pressures and edema (fluid retention in his feet and legs), and had not been updating the primary physician when blood pressures were elevated and edema was present. Family requested nursing home stay due to their concerns the group home setting was not meeting R35's health care needs. FAM-A stated the biggest issue they group homes were having with R35, was resident digging in / playing with his bowel movements. The group home he was in was not monitoring his behavior, and R35 was storing stool soiled clothing throughout his room. Family had ask for oversight, but it was not being done by the facility. During interview on [DATE] at 3:11 p.m., licensed social workers (LSW)-A and LSW-B stated they were unaware R35's Level II PASARR had not been completed by the COLSW. Both LSWs stated they assumed the Level II PASARR was complete and accurate. LSW-B stated R35's family were concerned resident's health needs were not being met in the group home setting. Both LSWs state they are not the ones who determine R35's length of stay, but rather the COLSW and DHS. LSW-B stated the County has historically been behind in assessments. A review of the facility's policy, entitled Pre-admission Screening and Resident Review (PASRR)-MN, last revised [DATE], the policy indicated the following: Developmental Disability (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Potential residents who are determined to have a developmental disability or related condition must be approved for admission by the state Developmental Disability Authority (DDA) and approval must include an approved length of stay prior to admission into the nursing facility.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 20794 Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed, accurate, and revised to assure assessed care needs were implemented for 1 of 2 residents (R35) reviewed for care planning. Findings include: R35's Annual Minimum Data Set (MDS), 11/05/2024; indicated R35 had diagnoses including anxiety disorder. In review of R35's History and Physical, dated 10/27/23, additional diagnoses included obsessive compulsive disorder (OCD) and Adjustment disorder with anxious mood. In review of R35' level I PASARR was completed on 10/30/23 prior to admission and indicated a PASARR level II was required before R35 admitted to a nursing facility, indicated the presence of a developmental disability. In review of R35's Level II PASARR (dated 11/09/23) indicated the diagnosis of Mild Intellectual Disability. In review of R35's care plan (last revised 11/13/24), R35 had a documented problem of: Problem Start Date: 11/22/2023 Category: Psychosocial Well-Being Resident has [PASARR] Level II for Persons with Mental Illness and or Intellectual Disability or a related condition due to DX of Obsessive-compulsive disorder, unspecified and Adjustment disorder with anxiety . Resident needs specialized services and the [PASARR] screening team has determined that resident meets the criteria for NF care. [NAME] County will provide or arrange for the following specialized mental health services. Goal: Resident will exhibit fewer mood symptoms of isolating self in the next 90 days and accept redirection and reassurance from staff and family. [Resident] will maintain active daily schedule per interests. Approaches: > Referral will be made to Senior Linkage Line for change of condition in accordance with MDS guidelines. > Referral will be made to Senior Linkage Line if resident has an inpatient psychiatric stay or (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	equally intensive treatment. > Resident will see their psychologist and psychiatrist on regular basis. In an interview on 12/6/24 at 8:40 a.m., LTC (long term care) clinical coordinator (LPN)-A stated the psycho-social care planning is completed by the social service department. LPN-A was unaware of any sessions with a psychologist or psychiatrist on regular basis. During an interview on 12/6/24 at 8:49 a.m., the facility licensed social workers (LSW)-A and LSW-B stated the facility has arrangements with Associated Clinic or Psychology (ACP), however, R35 had never received services while in the facility. LSW-B stated in conversations with R35's family, they did not feel these services were necessary. LSW-B stated R35's Care plan should have been updated. In review of the facility's policy, entitled: Care Plan and Baseline Care Plan (last revised 10/14/22) indicated the following: 3. The interdisciplinary team, in conjunction with the resident, resident's family, significant other or resident representative, shall develop a comprehensive person-centered care plan for each resident. This comprehensive care plan will be in the [electronic health record] by day 21 of the stay or 7 days after completion of the comprehensive initial MDS, whichever comes first. 4. The resident care plan is constantly changing. It should be updated routinely in the electronic record to reflect resident's current condition. The resident care plan is reviewed for accuracy, updated with quarterly MDS review, and all other scheduled MDS assessments.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observation, interview, and document review, the facility failed to comprehensively assess and implement interventions to ensure proper wheelchair positioning and prevent potential complications for 2 of 2 residents (R6 and R19) reviewed for wheelchair usage. Findings include: R6's quarterly Minimum Data Set (MDS) dated [DATE], identified R6 had severe cognitive impairment. R6's care plan identified R6 had a self-care deficit and required assistance with transfers and occasionally with locomotion and utilized a wheelchair. During observation on 12/3/24 at 4:07 p.m., R6 was being pushed down hallway in her wheelchair with no foot pedal on. R6's left foot was dragging and bouncing on floor. Staff did not provide reminders to R6 to hold her foot up. During observation on 12/4/24 at 12:47 p.m., R6 was being pushed down hallway in her wheelchair with no foot pedal on. R6's left foot was dragging and bouncing on floor. Staff did not provide reminders to R6 to hold her foot up. During observation on 12/4/24 at 4:32 p.m., R6 was being pushed down hallway in her wheelchair with no foot pedal on. R6's left foot was dragging and bouncing on floor. Staff did not provide reminders to R6 to hold her foot up. During observation on 12/6/24 at 9:10 a.m., R6 was being pushed down hallway in her wheelchair with no foot pedal on. R6's left foot was dragging and bouncing on floor. Staff did not provide reminders to R6 to hold her foot up. R19's quarterly Minimum Data Set (MDS) dated [DATE], identified R19 had cognitive impairment. Further, R19's care plan identified R19 had a self-care deficit and required assistance with transfers and locomotion in a wheelchair to reach desired destinations and utilized a wheelchair. During observation on 12/2/24 at 11:36 a.m. R19 was being pushed down hallway in his wheelchair with no foot pedals on. R19's feet were dragging and bouncing on floor. Staff did not provide reminders to R19 to hold his feet up. During observation on 12/3/24 at 11:49 a.m. R19 was being pushed down hallway in his wheelchair with no foot pedals on. R19's feet were dragging and bouncing on floor. Staff did not provide reminders to R19 to hold his feet up. During observation on 12/3/24 at 4:52 p.m. R19 was being pushed down hallway in his wheelchair with no foot pedals on. R19's feet were dragging and bouncing on floor. Staff did not provide reminders to R19 to hold his feet up. During observation on 12/4/24 at 4:39 p.m., foot pedal was observed laying on top of R19's walker along the wall in his room. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 12/6/24 at 9:08 a.m. R19 was being pushed down hallway in his wheelchair with no foot pedals on. R19's feet were dragging and bouncing on floor. Staff did not provide reminders to R19 to hold his feet up. During interview on 12/4/24 at 3:25 p.m., nursing assistant (NA)-A stated foot pedals are used as needed. NA-A stated R6 has one foot pedal that should be used if staff are assisting her with propelling wheelchair. NA-A stated R19 has foot pedals that staff use as needed. During interview on 12/6/24 at 9:01 a.m., trained medication aide (TMA)-A stated foot pedals should be used for any resident who had them and needed staff assistance transporting to and from any destination. TMA-A stated R6 does not have or use foot pedals. TMA-A stated R19 does not use foot pedals often. During interview on 12/6/24 at 9:19 a.m., licensed practical nurse (LPN)-A stated foot pedals are used when the resident is not about to pick up their feet or needed assistant with keeping their feet off the floor. LPN-A stated foot pedals should be used for residents who are not able to keep their feet up when staff pushed the wheelchair to and from destinations. R6 did not use foot pedals. Foot pedals should be used for R19 if he was not picking his feet up. LPN-A stated she expected staff to utilize foot pedals in all observations noted above. LPN-A stated it was important for foot pedals to be used for safety when escorting residents in a wheelchair to and from destinations and to prevent injuries. During interview on 12/6/24 at 9:48 a.m., director of nursing (DON) stated that foot pedals are assessed upon admission and would be accessible when needed. DON stated foot pedals are not always on the wheelchair but are stored in resident's room to be used as needed. When a resident was exhibiting signs of not being able to keep feet held off floor when being transported to and from destinations, DON expected foot pedals be placed on wheelchair and used. She expected staff to use foot pedals in all observations noted above. DON stated it was important to use foot pedals on wheelchair during transport to prevent injury and that it was best practice. A wheelchair positioning policy was requested but was not provided.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to follow a care planned intervention to prevent or reduce the risk of aspiration for 1 of 2 residents (R7) reviewed for nutrition and needing supervision at meals. Findings include: R7's quarterly Minimum Data Set (MDS) dated [DATE], identified R7 had intact cognition and required assistance with all activities of daily living (ADL)'s. R7's diagnoses included traumatic brain dysfunction, unspecified intracranial injury with loss of consciousness of unspecified duration, hypertension, peripheral vascular disease, hemiplegia, traumatic brain injury, depression, polyneuropathy, dysphagia - oropharyngeal phase, dysarthria and anarthria, osteoarthritis, chronic kidney disease and bicipital tendinitis. MDS indicated R7 needed supervision or touching assistance with eating. R7's Nutrition Care Area Assessment (CAA) dated 7/23/24, identified R7 was at risk for swallowing problems due to dysphagia, need for special diet or altered consistency which might not appeal to resident and the inability to perform self-care or mobility without significant physical assistance. CAA indicated R7 was currently on a pureed diet with mildly (nectar) thick liquids, facility to continue to provide diet per order and observe weights and intakes for changes. No referrals at this time, will proceed to care plan with goal to tolerate food and fluids served. R7's care plan, print date of 12/4/24, identified R7 required a pureed diet (in smooth applesauce consistency) with mildly thick liquids (nectar) related to dysphagia with instructions to thicken liquids more if coughing. R7 utilized adaptive equipment to increase independence at meals (lipped plate and Kennedy cup). Staff was to provide close supervision at his table to control pacing and remind him to stop and swallow when he started coughing, resident's preference was to sit at a table by himself, resident used bedside table to eat in dining room. Care plan also identified R7 had an alteration in activities of daily living (ADLs) related to history of traumatic brain injury with subsequent hemiplegia/hemiparesis affecting right dominant side, weakness, osteoarthritis, polyneuropathy, and pain, at risk for decline in ADLs. An intervention directed staff to provide close supervision with all meals for pacing assist and to remind resident to place silverware down between bites and monitor bite size. R7's physician orders, print date of 12/4/24, included orders to assist resident with feeding to control bite size and diet of puree food in smooth/applesauce consistency with mildly/nectar thick liquids (if coughing, thicken more). Diet order included special instructions of close supervision to control pacing and remind him to stop and swallow when he started coughing. R7's quarterly nutrition review progress note, dated 10/14/24, indicated staff was to thicken liquids more if R7 was coughing and that R7 required close supervision when eating. Progress note also indicated R7 was to receive assistance at meal to control bite size/pacing and remind him to stop and swallow when starts coughing. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 12/3/24 at 12:04 p.m., R7 was seated at table in dining room drinking chocolate milk out of Kennedy cup. At 12:08 p.m., R7 received a lipped plate and was using his left hand to eat with regular silverware. R7's food was pureed and fluids were appropriately thickened. R7 was struggling to get food to his mouth due to not being able to flex left arm at the elbow. R7 took large spoonfuls of food and would take one spoonful after another without pacing between bites. At 12:26 p.m., R7 began coughing and had a non-productive cough that lasted several seconds. Staff did not intervene when R7 was coughing. No staff were present at his table and did not provide reminders to R7 throughout meal. Staff seated two tables away assisting another resident with eating. During observation on 12/3/24 at 5:08 p.m., R7 was seated at table in dining room and dietary staff delivered plate. R7's food was pureed and fluids were appropriately thickened. R7 was again struggling to get food to his mouth and had food dripping down face. Resident took large spoonfuls of food and would take one spoonful after another without pacing between bites. At 5:20 p.m., R7 continued sitting at table alone. At 5:36 p.m., R7 was assisted out of dining room by staff. No staff were present and did not provide reminders to R7 throughout meal. During observation on 12/4/24 at 12:08 p.m., R7 was sitting at table in dining room. R7's food was pureed and fluids were appropriately thickened. R7 was again struggling to get food to his mouth. At 12:16 p.m., R7 had food dripping down his face. At 12:17 p.m., R7 began coughing and had a non-productive cough. At 12:23 p.m., dietary staff went to R7's table, gathered dirty clothing protector and left table. At 12:24 p.m., staff asked R7 if he was finished, R7 nodded his head yes. At 12:28 p.m., staff assisted R7 out of dining room. No staff were present and did not provide reminders to R7 throughout meal. During interview on 12/4/24 at 3:27 p.m., nursing assistant (NA)-A stated R7 received pureed thickened foods due to difficulty swallowing. NA-A stated she was not aware of any other assistance R7 needed at mealtimes. During interview on 12/6/24 at 9:01 a.m., trained medication assistant (TMA)-A stated R7 was able to feed himself but needed close supervision which consisted of watching for coughing and monitoring bite size. TMA-A stated if R7 was taking too big of bites, staff were to provide reminders to R7 to slow down and watch bite size and staff may need to help with feeding as needed. During interview on 12/6/24 at 9:19 a.m., licensed practical nurse (LPN)-A stated R7 was independent with eating but needed supervision with ensuring he is not eating too much and providing reminders to take smaller bites and to slow down. LPN-A stated R7 did not need any assistance with eating but if staff heard any coughing they would go and check on his. LPN-A confirmed R7 had an order for close monitoring when eating. LPN-A stated it was important to ensure close supervision was occurring during mealtimes to ensure that R7 did not choke or aspirate on food. LPN-A stated staff should be providing reminders regarding bite size and to slow down when eating. During interview on 12/6/24 at 9:55 a.m., director of nursing (DON) stated R7 needed close supervision with meals as ordered and staff should be in close proximity to R7, so they are able to offer reminders as warranted. DON stated it was important to follow these orders/instructions as it was ordered for R7's safety and to work on R7 controlling his pace and reducing the risk for aspiration. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Feeding of residents by staff policy, dated 3/27/24, indicated residents unable to feed themselves will be provided with assistance per their care plan. Staff sit at eye level with resident and offer small bite-sized portions on the fork or spoon at a regular rate.		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to promptly obtain diuretic medication and failed to notify the physician to prevent the continued increase of carbon dioxide for 1 of 2 residents (R24) reviewed for medication errors. This practice resulted in a significant medication error and actual harm when R24 did not receive medication for 4 consecutive days resulting in R24 being sent to the emergency room to receive care for acute onset chronic respiratory failure with hypoxia (condition in which the body or a region of the body is deprived of adequate oxygen supply at the tissue level) and hypercapnia (condition where there is too much carbon dioxide (CO2) in the blood). Findings include: R24's quarterly Minimum Data Set (MDS) dated [DATE], identified R24 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R24's diagnoses included acute on chronic diastolic heart failure, hypertension, hyponatremia, schizophrenia, chronic obstructive pulmonary disease, respiratory failure, acute and chronic respiratory failure with hypoxia, paroxysmal atrial fibrillation, acute kidney failure, dysphagia, and emphysema. R24's physician's order dated 10/25/2024, identified R24 was prescribed 250 milligrams (MG) of oral Diamox (diuretic medication) twice daily for increased CO2 and hypercapnia. Review of R24's laboratory results for labs drawn on 10/25/24, indicated R24's CO2 levels were greater than 45 mmol/L (millimoles per liter). The range for normal CO2 levels are between 20 to 29 mmol/L. Review of R24's medication administration record (MAR) from 10/21/24 to 11/3/24, identified Diamox was ordered on 10/25/24 but was not administered to R24 for a total of eight doses. Seven of the eight doses (10/25/24 through 10/28/24) indicated Not Administered: Drug/Item Unavailable. Dose on 10/29/24 indicated Not Administered: Drug/Item Unavailable - Comment: called A&E for supply. R24's progress notes from 10/25/24 to 10/29/24 gave no indication R24's Diamox prescription was never received from pharmacy or R24's provider was contacted. Progress notes failed to identify any attempt to receive or follow up on R24's Diamox medication. R24's progress note dated 10/29/24 at 11:04 a.m., indicated resident was sent to the emergency department (ER) due to difficulty breathing, severe low oxygen saturations (69%), high respirations (32 breaths per minute) and skin was gray in color. (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0760 Level of Harm - Actual harm Residents Affected - Few	R24's hospital discharge summary dated 11/1/24, identified principal diagnoses of acute on chronic respiratory failure with hypoxia and hypercapnia. The following criteria for acute respiratory failure were met; increase of at least 2L (liters) from chronic home O2 (oxygen), PCO2 (partial pressure of arterial carbon dioxide) greater than 50, O2 sats less than 89% more than once, and respiratory rate greater than 20 breaths per minute. Summary indicated shortness of breath, at baseline resident on 3L oxygen and needed up to 15L of oxygen and now back down to 3L, although no wheezing patient had significantly diminished air entry to the bases, was retaining CO2 and likely leading to increased work of breathing and addition of oral prednisone (steroid) for 5 days. R24 was discharged from hospital and returned to facility on 11/1/24 at 1:30 p.m. During interview on 12/4/24 at 10:42 a.m., pharmacist stated Diamox was a lot like Lasix as it helped to rid body of excess fluid and worked by inhibiting the enzymes as it disrupted the balance between acid base ratios. Potential side effects of not receiving the medication would be shortness of breath. Pharmacist stated R24 not receiving eight doses of medication contributed to resident being sent to the ER for increased CO2 and hypercapnia. She would considered this a significant medication error as it would affect her breathing. Pharmacist stated medication was filled on 10/29/24 from the original prescription that was prescribed in April 2024 for once daily. She was not able to find an order, that was prescribed in October, for Diamox twice daily in the system. Pharmacist stated facility may not have sent the updated prescription to the pharmacy. During interview on 12/5/24 at 8:05 a.m., trained medication aide (TMA)-B stated if a medication was not available, she would notify the nurse. TMA-B stated the nurse does the communication/ordering of medications. TMA-B stated she would write down medications that are needed and give them to the nurse as it is sometimes difficult to get things. TMA-B stated if it had been a couple of days and medication was still not available, she notified the nurse again to remind to call pharmacy to see where medication was. During interview on 12/5/24 at 9:01 a.m., nurse practitioner (NP) stated medication was prescribed on 10/25/24 on the direction of Dr. [NAME] for increasing CO2 and hypercapnia based on labs that were obtained on 10/25/24. NP stated she was not aware of facility notifying her of resident not receiving medication. NP stated R24 was sent to the ER due to her history of COPD (chronic obstructive pulmonary disease) and CO2 retention. During interview on 12/5/24 at 10:20 a.m., TMA-C stated if medication was not available, she would first check the Omnicell to see if medication was available and if not, she would report it to the nurse by writing it on her report sheet. TMA-C stated the nurse was the only one that does the communication with pharmacy. TMA-C stated director of nursing (DON) talked to her on 12/3/24 regarding her process if medication was not available. During interview on 12/5/24 at 10:46 a.m., health unit coordinator (HUC)-A and HUC-B stated when a new order was received, they enter the order in the electronic health record (EHR), place the order in file folder for nurse to review and scans the order to their email to send to pharmacy. HUC-A and HUC-B stated they did not have any confirmation page/email that order was sent to pharmacy. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Lake Ridge Care Center of Buffalo, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 310 Lake Boulevard Buffalo, MN 55313	
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F 0760 Level of Harm - Actual harm Residents Affected - Few	During interview on 12/5/24 at 10:58 a.m., licensed practical nurse (LPN)-B stated if a TMA was unable to find a medication, they should go and look in the Omnicell for medication. If medication was not available in the Omnicell, TMA should tell nurse who would call the pharmacy and document the communication in the progress notes. LPN-B stated new orders are entered in the EHR and sent to pharmacy by the HUC and then the nurse would go and verify the order. LPN-B stated she did not remember this medication or if she contacted pharmacy. LPN-B stated if she had contacted pharmacy, she would have documented it in a progress note. LPN-B stated she does not recall being updated by any TMA's that medication was not available. During interview on 12/5/24 at 11:39 a.m., TMA-D stated if medication was not available, she would check the Omnicell and would then notify the nurse. TMA-D stated the nurse was the one that follows up with pharmacy regarding medications. During interview on 12/5/24 at 12:29 p.m., LPN-C stated if medication was not available, Omnicell should be checked for availability. Pharmacy would then be called to check on the status and would also check the medication receipt book from pharmacy to see if medication had been delivered. LPN-C stated a progress note would be documented regarding communication with the pharmacy. During interview on 12/5/24 at 12:39 p.m., DON stated she expected the nurse to contact pharmacy to get clarification on what was happening with delivery of any medication not received. She expected the TMAs to communicate to the nurse on duty when a medication was not available. Some nurses documented pharmacy communication in progress notes, and some documented it on the medication administration record (MAR). DON stated it was best practice to document all communication with providers. New orders were transcribed by the HUC and then placed in the unit folder for the nurse to verify order. DON stated the HUC sent orders to the pharmacy upon transcription of order. DON stated she was on medical leave at the time of medication error and that a preliminary investigation was completed by a LPN-A but was not thoroughly completed. From a clinical standpoint, there was a critical lab value, and we did not give the medication that was prescribed to mitigate the risk. If medication was administered as prescribed, they may not have needed to send R27 to the hospital. During interview on 12/6/24 at 9:19 a.m., LPN care coordinator-A stated if a medication was not available, the TMA would check the Omnicell to see if medication was available and if medication was not in Omnicell, TMA would notify the nurse. LPN-A stated the nurse would call the pharmacy to check on the status of the medication. LPN-A stated she would expect the nurse to document any communication with pharmacy or providers. LPN-A stated she was notified on 10/29/24 that R24 had not received any Diamox that was prescribed on 10/25/24. She followed up with pharmacy, was informed the medication would be out for delivery on the night of 10/29/24. LPN-A stated she started the incident event in the EHR and mentioned the incident to a couple of people but did not do any other investigation and/or interviews regarding incident. During interview on 12/6/24 at 10:00 a.m., DON stated that she was in the middle of investigating the incident when she talked to surveyor on 12/5/24. DON identified if it wasn't charted, it wasn't done and confirmed no documentation was found regarding incident. DON stated education and new procedures were implemented in the past 12 hours to prevent reoccurrence. Changes to procedure consisted of proper communication chains, reminders of what to do when a medication was not available, changed the option in the EMR where TMAs are not able to use the drug unused/unavailable feature and education of placing a progress note on all communications that have transpired. (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During interview on 12/6/24 at 10:26 a.m., medical director stated the facility had not made him aware of this medication error and found it during his monthly review of incidents and pharmacy review. Medical director stated communication was not timely. The facility Medication Administration policy, dated 10/8/24, indicated medications will be administered by licensed nurses or trained medication aides under the supervision of a licensed nurse. The facility Ordering Medication policy, dated 10/8/24, indicated if medication was not found, staff to look on the printed sheet to verify that it was filled and look for the medication before calling the pharmacy. If, after searching, staff cannot find the medication and it is not in the printout as being sent, call the pharmacy. The facility Trained Medication Aide job description, dated 12/8/2023, indicated TMAs are to report medication refused or not given to the overseeing nurse. The facility Licensed Practical Nurse job description, undated, indicated LPNs coordinated medications, supplies and equipment including ordering, receiving, storing, and disposing of all items in accordance with facility policies and procedures.		