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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 04UH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00587

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245138**
2.STATE VENDOR OR MEDICAID NO.
(L2) **122747501**

3. NAME AND ADDRESS OF FACILITY
(L3) **BOUNDARY WATERS CARE CENTER**
(L4) **200 WEST CONAN STREET**
(L5) **ELY, MN** (L6) **55731**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **10/01/2011**

6. DATE OF SURVEY **01/25/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 02/5/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/05/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/24/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 01/11/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245138

February 5, 2016

Ms. Shelley Solberg, Administrator
Boundary Waters Care Center
200 West Conan Street
Ely, MN 55731

Dear Ms. Solberg:

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 January 8, 2016 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
February 5, 2016

Ms. Shelley Solberg, Administrator
Boundary Waters Care Center
200 West Conan Street
Ely, MN 55731

RE: Project Number S5138026

Dear Ms. Solberg:

On December 14, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 3, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 25, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 29, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 3, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 8, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 3, 2015, effective January 8, 2016 and therefore remedies outlined in our letter to you dated December 14, 2015, will not be imposed.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245138 Y1	A. Building B. Wing Y2	1/25/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BOUNDARY WATERS CARE CENTER	200 WEST CONAN STREET ELY, MN 55731

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0278	Correction	ID Prefix F0279	Correction	ID Prefix F0280	Correction
Reg. # 483.20(g) - (j)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed
LSC	01/08/2016	LSC	01/08/2016	LSC	01/08/2016
ID Prefix F0329	Correction	ID Prefix F0371	Correction	ID Prefix F0372	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.35(i)	Completed	Reg. # 483.35(i)(3)	Completed
LSC	01/08/2016	LSC	01/08/2016	LSC	01/08/2016
ID Prefix F0406	Correction	ID Prefix F0412	Correction	ID Prefix F0428	Correction
Reg. # 483.45(a)	Completed	Reg. # 483.55(b)	Completed	Reg. # 483.60(c)	Completed
LSC	01/08/2016	LSC	01/08/2016	LSC	01/08/2016
ID Prefix F0441	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed	Reg. #	Completed
LSC	01/08/2016	LSC	01/08/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	LB/kfd	02/05/2016	28035	1/25/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/3/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245138 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/29/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BOUNDARY WATERS CARE CENTER	200 WEST CONAN STREET ELY, MN 55731

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0011	Correction Completed 01/08/2016	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 12/09/2015	ID Prefix Reg. # NFPA 101 LSC K0067	Correction Completed 01/08/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	02/05/2016	27200	1/29/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/3/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 04UH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00587

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245138**

2.STATE VENDOR OR MEDICAID NO.
(L2) **122747501**

3. NAME AND ADDRESS OF FACILITY
(L3) **BOUNDARY WATERS CARE CENTER**
(L4) **200 WEST CONAN STREET**
(L5) **ELY, MN** (L6) **55731**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **10/01/2011**

6. DATE OF SURVEY **12/03/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Theresa Guillingsrud, HFE NEII 12/28/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/08/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/24/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 01/11/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5138

A standard survey was completed at this facility on December 3, 2015. Deficiencies were cited, the most serious at a scope and severity level of F. The facility has been given an opportunity to correct before remedies would be imposed. In addition, at the time of the standard survey, an investigation of complaint number H5138015 was conducted and found to be unsubstantiated.

Refer to the CMS 2567 for both health and life safety code along with the facilitys plan of correction. Post Certification Revisit (PCR) to follow.

Minnesota Department of Health

Electronically delivered
December 14, 2015

Ms. Shelley Solberg, Administrator
Boundary Waters Care Center
200 West Conan Street
Ely, Minnesota 55731

RE: Project Number S5138026, H5138015

Dear Ms. Solberg:

On December 3, 2015, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 3, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5138015 that was found to be unsubstantiated.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 12, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 12, 2016 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition
of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 March 3, 2016 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 3, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245138	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOUNDARY WATERS CARE CENTER	**200 WEST CONAN STREET ELY, MN 55731**

(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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Investigation of complaint H5138015 was also completed. The complaint was not substantiated.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278		1/8/16

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

Electronically Signed | 12/23/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245138	A. BUILDING _____ B. WING _____	12/03/2015

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F 278	Continued From page 1 subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set assessment was accurately coded to reflect the oral status for 1 of 1 residents (R9) reviewed for dental and had missing, broken teeth. Findings include: R9's Face Sheet dated 10/16/15, indicated R9 was diagnosed with dementia, alcohol dependency (ETOH), adult neglect or abandonment, anxiety and chronic obstructive pulmonary disease (COPD). R9's initial Minimum Data Set's (MDS) dated 8/17/15, indicated R9 had severely impaired cognition and required extensive assistance for activities of daily living. The MDS had not identified R9 had broken or missing teeth. On 12/01/2015, at 10:04 a.m. R9 was observed to have several upper and lower missing teeth. On 12/2/15, at 8:00 a.m. R9 was observed during	F 278	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. The MDS assessment for R9 was reviewed and modified as appropriate regarding dentition. Discussion with guardian also found that R9 did have regular dental visits until a decrease in cognition and significant increase in anxiety interfered about 2 years ago and now is considered a very traumatic event for this specific resident. 2. MDS Coordinator has been educated regarding the MDS assessments. The MDS Assessments will be reviewed per the MDS schedule for all other residents that reside at BWCC.	

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F 278	Continued From page 2 the breakfast meal. R9 was provided a mechanical soft diet and did not have any trouble eating/chewing the meal which included a pancakes, sausage, donut and juice. On 12/2/15, at 9:05 a.m. R9 was observed to have missing teeth and when she opened her mouth, her back teeth/molars were black in color. R9's medical record was reviewed and a comprehensive oral assessment was not found. The following medical record notes revealed the following: R9's 8/18/15, Initial Assessment of all systems identified R9 having missing teeth. R9's 9/21/15, dietitian note indicated R9 was on mechanical soft textured food due to lack of dentition and poor dentition, was able to feed self, was limited by her dementia related to ETOH, and anxiety related to previous living arrangement. R9's 9/17/15, physician note indicated R9 had poor dentition. The note indicated R9 did have an appointment scheduled in the near future with a dentist and diet was changed to mechanical soft. R9's 10/26/15, nursing note indicated R9 had poor dentition. On 12/3/15, at 9:30 a.m. registered nurse (RN)-A verified R9's 8/17/15, MDS was incorrectly coded. RN-A stated she knew R9 had missing teeth and the teeth in the back of her mouth were black. A policy on completing the oral/dental section of	F 278	3. 3 random MDS assessments will be audited weekly by DON and or designee for 4 weeks then monthly thereafter for 3 months. 4. DON/Designee will report results and trends of all audits to the QA&A committee for review and follow up as needed. 5. Completion date 01/08/2015	

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F 278	Continued From page 3 the MDS was requested however, no policy was received.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop care plans which identified the use of antidepressant and / or gastric medications for 1 of 5 residents (R5, R1) reviewed for unnecessary medicaiton and was administered the medications. Findings include:	F 279	1. R1 and R5 care plans have been reviewed and updated to identify the use of antidepressant/ and or gastric medications. 2. Other residents who receive antidepressant/and or gastric medications have been reviewed and care plans updated as appropriate with	1/8/16

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F 279	Continued From page 4 R5 received Trazadone and Prilosec which was not identified on the care plan. R5's The current physician's orders/ Discharge Summary dated 10/7/15, included Prilosec (medication to reduce stomach acid) 20 milligrams (mg) daily. The discharge summary did not include a diagnosis for the medication. The discharge summary also included an order for Trazadone (an antidepressant medication) 50 mg at bedtime as needed for insomnia. R5's care plan dated 10/13/15, did not identify any concerns related to gastric distress or insomnia or the use of the medications. R5's The Medication Administration Record (MAR) for October 2015, indicated R5 had received two doses of Trazadone (10/9/15, and 10/16/16) and had received Prilosec daily. R5's November 2015, MAR indicated R5 had not received Trazadone but had received Prilosec daily. R5's December 2015, MAR indicated R5 had received Prilosec daily but had not received the Trazadone. On 12/2/15, at 1:50 p.m. the director of nurses (DON) verified R5's care plan had not been developed to identify the use of Trazadone and Prilosec due to insomnia / gastric concerns. R1 received Prilosec daily and the care plan	F 279	nonpharmacological interventions. Weekly care plan meetings will occur per the care conference schedule to determine appropriateness of the interventions. IDT team has been educated on the importance of care plans being updated that reflect the need for specific medications, along with the diagnosis for these medications and interventions as well as nonpharmacological interventions. 3. 3 random care plans will be reviewed by DON and or designee weekly for 4 weeks then monthly thereafter for 3 months. 4. DON/Designee will report results and trends of all audits to the QA&A committee for review and follow up as needed. 5. Completion date 01/08/2015	

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F 279	Continued From page 5 lacked indication of use. R1's 9/9/15, quarterly MDS dated 9/9/15, indicated had intact cognition and was diagnosed with congestive heart failure, anemia and diabetes mellitus. R1's physician's orders dated 5/22/25, indicated an order for Prilosec delayed release 40 milligrams (mg) daily. R1's 12/1/15, MAR indicated Prilosec delayed release 40 mg. daily for stomach. R1's care plan printed on 12/3/15, lacked identification of the use of Prilosec. On 12/3/15, at 8:15 a.m. the DON verified the use of Prilosec was not addressed on R1's care plan. The Care Plan Policy dated 4/1/08, directed the staff to develop a comprehensive care plan for each resident.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280		1/8/16

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F 280	Continued From page 6 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the care plan was revised to reflect non pharmalogical interventions for the use of mood altering medication for 2 of 5 residents (R5, R9) who received mood altering medications. Findings include: R5's care plan did not address non-pharmacological interventions to be attempted prior to the use of as needed medications (PRN) antianxiety medication. R5's current physician's orders/ Discharge Summary dated 10/7/15, included an order for Ativan (antianxiety medication) 0.5 milligrams (mg) every four hours as needed for anxiety. The Ativan order also included special instructions to to "avoid if delirium present." R5's care plan dated 10/13/15, indicated R5 experienced anxiety and directed staff to monitor for hallucinations. The care plan did not include individualized non-pharmacological interventions to be attempted prior to the administration of the	F 280	1. R5 and R9 care plans have been reviewed and updated to reflect nonpharmacological interventions for the use of mood altering medications. 2. Other residents who receive mood altering medications have been reviewed and care plans updated as appropriate with nonpharmacological interventions. Weekly care plan meetings will be occurring per the care conference schedule to determine appropriateness of the interventions and will reflect updates as deemed appropriate related to non-pharmacological interventions. IDT team has been educated on the importance of the non-pharmacological interventions. 3. 3 random care plans will be reviewed by DON and or designee weekly for 4 weeks then monthly thereafter for 3 months. 4. DON/Designee will report results and trends of all audits to the QA&A	

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F 280	Continued From page 7 PRN medication. R5's Medication Administration Record (MAR) for October 2015, indicated R5 had received six doses of Ativan (10/19, 10/22, 10/24, 10/26, 10/27, and 10/30/15). R5's November 2015, MAR indicated R5 had received three doses of Ativan (11/14, 11/25 and 11/28). R5's December 2015, MAR indicated R5 had not received Ativan. At 2:00 p.m. the director of nursing (DON) verified R5 had received Ativan and R5's care plan did not include non-pharmacological interventions to be attempted prior to the administration of the medication. The DON verified R5's care plan was in need of revision. R9's care plan did not address the usage of a medication for insomnia. R9's current physician's orders dated 9/14/15, directed staff to administer Trazodone HCL tablet 150 mg by mouth at bed time for sleep. R9's care plan dated 11/16/15, lacked identification of insomnia or monitoring of individualized insomnia symptoms. In addition, the care plan lacked evidence that non-pharmacological approaches were tried before the administration of the medication. The care plan indicated R9 used antidepressant medication-trazodone related to anxiety however, the physician wrote the trazodone order for insomnia.	F 280	committee for review and follow up as needed. 5. Completion date 01/08/2015	

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F 280	Continued From page 8 On 12/2/15, at 11:43 a.m. the director of nursing (DON) verified R9's care plan needed to be revised and was on Trazadone due to not sleeping. In addition, the DON verified R9's care plan lacked any indication R9 had insomnia, received medication to induce sleep, non pharmalogical interventions to be attempted or signs/symptoms of adverse reactions to monitor for.	F 280		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		1/8/16

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F 329	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify clinical indications for the continued use of medications for 3 of 6 residents (R42, R5, R9, R1) and failed to identify non-pharmacological interventions prior to the use of anti-anxiety medication for 1 of 2 residents (R5) who received anti-anxiety medications. Findings included: R42's record lacked clinical indications for the continued use of Risperdal (an antipsychotic medication). R42's Admission Record dated 10/16/15, indicated R42 had diagnoses that included mild intellectual disabilities, anxiety, dementia with behavioral disturbance and insomnia. R42's quarterly Minimum Data Set (MDS) dated 10/05/15, indicated R42 had moderate cognitive impairment. The MDS indicated R42 experienced no mood symptoms, no psychosis, hallucinations or delusions and exhibited no behavioral symptoms, rejection of care or wandering. The MDS also indicated R42 was independent with bed mobility, transfers, locomotion on and off the unit, ambulation and eating, required limited assistance of one person for dressing and required extensive assistance of one person for toilet use and personal hygiene. The MDS further indicated R42 received antipsychotic and antidepressant medication daily.	F 329	1. R1, R5, R9, R42 medications have been reviewed and changed to identify clinical indications for the continued use of anti-anxiety and anti-psychotic medications. Sleep studies will be completed for R5 and R9 2. Review of all resident medications has been completed to validate appropriate use of medications and associated diagnosis. Target behaviors will also be reviewed to determine appropriateness. Medication changes have occurred if deemed appropriate by the residents primary care physician. Nursing has educated staff related to target behaviors. 3. Medications will continue to be reviewed per the monthly medication review meetings. Log will be maintained that will identify appropriate use, to include diagnosis and other interventions that should be utilized prior to administering medications. Monitoring will be completed by DON and or designee. 4. DON/Designee will report results and trends of all audits to the QA&A committee for review and follow up as needed. 5. Completion date 01/08/2015	

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F 329	Continued From page 10 R42's Psychotropic Drug Use Care Area Assessment (CAA) dated 4/22/15, indicated R42 received a daily antidepressant and antipsychotic for mood disorder. The CAA indicated staff would monitor and consider dose reductions in the future to have R42 at lowest and most effective dose for her quality of life. R42's Medication Review Report dated 10/8/15, identified orders that included but were not limited to Risperdal 1 milligram (mg) by mouth daily in the a.m. for mood with a start date of 4/17/15, and Risperdal 2 mg by mouth at bedtime for mood with a start date of 4/16/15. R42's care plan dated 10/23/15, indicated R42 used psychotropic medications Risperdal and Effexor (antidepressant medication) for anxiety, depression and behavior management. The care plan directed staff to monitor for target behaviors of: mood swings related to depression or episodes with potential of self isolation, not eating, or aggressive behavior. The care plan indicated staff was to implement interventions for the target behaviors that included: 1 to 1, redirect, offer activity, encourage to verbalize feelings, calmly ask her to go back to her room. The care plan also directed staff to review target behaviors monthly for trending and effectiveness of interventions. On 12/02/2015, at 7:59 a.m. R42 ambulated independently with a walker to a table in the dining room. R42 greeted fellow residents and smiled. No target behaviors observed. On 12/02/2015, at 8:12 a.m. the director of nursing (DON) brought R42 her medications. The interaction between R42 and DON was	F 329		

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F 329	Continued From page 11	F 329		

cordial. R42 was observed to pour coffee for her tablemate's. No target behaviors were observed.

On 12/02/2015, at 11:10 a.m. the activities director (AD) approached R42 in the television lounge area and asked R42 if she would like to do a word search puzzle. R42 indicated she loved doing them and thanked AD for giving her the puzzle. R42 remained seated in the lounge area drinking coffee and watching television with three other residents. No target behaviors observed.

On 12/02/2015, at 1:53 p.m. R42 had remained seated in the lounge area since after lunch watching a movie with two other residents. R42 was attentive to the movie, conversed with staff and visitors and was pleasant and smiling. No aggressive behavior or other target behaviors observed.

Review of R42's Medication Administration Record (MAR) from 9/1/15 through 12/2/15, revealed orders for Risperdal 1 mg by mouth in the a.m. and 2 mg by mouth at bedtime, daily, for mood. The MAR indicated R42 was administered the medication daily when in the facility.

R42's Behavior/Intervention Monthly Flow Record from 10/1/15, through 12/2/15, were reviewed and revealed R42 was monitored for the following target behaviors: mood swings related to depression as manifested by manic or depressive episodes with potential of self isolation, not eating or aggressive behavior. The Flow Records revealed the following behavior history:
--10/1/15: Number of behavior episodes: 2. Interventions: redirect, 1 to 1, offered activity,

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F 329	Continued From page 12 encouraged verbalization of feelings. Outcome: improved. R42's Consultant Pharmacist's (CP) Medication Regimen Reviews were reviewed from 5/15/15, to 11/25/15 and revealed the following: --On 5/15/15 the CP's Note to Attending Physician/Prescriber indicated R42 was using Risperdal and requested a documented diagnosis for the use of the medication. --On 6/3/15, the Physician/Prescriber response indicated the information would be obtained from the previous provider, if able. The response also indicated R42 had episodes of agitation and history of aggression. --On 10/20/15, the CP's Note to Attending Physician/Prescriber indicated R42 used Risperdal 1 mg every a.m. and 2 mg every bedtime with doses steady since admission to the facility. The CP requested: Please evaluate the appropriateness of a dose reduction in the patient's daily dosage to ensure that the lowest effective dose is being used. If a reduction is not indicated at this time, please document. --On 11/12/15, the Physician/Prescriber response indicated R42 had outbursts at times with the current dose and could be re-directed by staff and would continue with current dose. No further recommendations were made. Review of physician progress notes revealed: --A past clinic visit from a previous provider dated 3/13/15, included chronic problems that included mild mental retardation and dementia and past medical history that included depression. --R42's Nursing Home Note dated 11/24/15, indicated R42 had anxiety under relatively good control and was on Risperdal. The note indicated	F 329		

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	245138	A. BUILDING _____ B. WING _____	12/03/2015

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F 329	Continued From page 13 R42 had a mild tremor in her hands that was likely an essential tremor and the physician would watch for now. The medical record lacked documentation of an indication for the use of Risperdal and documentation of a history of hallucinations, delusions or psychosis. On 12/03/2015 8:30 a.m. nursing assistant (NA)-D stated they monitored R42 for for behaviors such as verbal comments or aggression. NA-D stated when these behaviors occurred, they would redirect R42 and she was usually fine. NA-D stated she didn't think R42 had any delusions, hallucinations or psychosis but to check with the nurse. On 12/03/15, at 9:25 a.m. the DON stated the facility had a difficult time obtaining R42's past medical records to determine an indication for her medication. The DON indicated when the records were received they had included a diagnoses of dementia and at that time the diagnosis of dementia with behavioral disturbance was added to the record for the use of Risperdal. The DON verified there was no documentation in the record of R42 having had any history of hallucinations or delusions and confirmed the diagnosis was not adequate for the continued use of the medication. On 12/03/2015, at 10:20 a.m. the consultant pharmacist (CP) confirmed a request for an indication for the use of Risperdal was requested 5/15/15, and dementia with behavioral disturbance was given. The CP indicated he noted target behaviors were identified and being monitored but confirmed he did not note the type of behaviors. The CP confirmed he should have recognized the behaviors being monitored were	F 329		

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F 329	Continued From page 14 not appropriate for the continued use of anti-psychotic medication. R5's medication had not been reviewed for the potential of unnecessary medication. R5's quarterly MDS dated 11/13/15, indicated R5 had severe cognitive impairment and diagnoses including osteoporosis and a history of dehydration. During the survey conducted on 11/20/15, from 4:00 p.m. to 8:00 p.m., on 12/1/15, from 8:00 a.m. to 4:30 p.m., on 12/2/15, from 7:00 a.m. to 3:30 p.m. and on 12/3/15, from 8:00 a.m. to 12:00 p.m. R5 was observed to rest in her bed, was fed her meals in bed and received all personal cares in bed. R5's current physician's orders/ Discharge Summary dated 10/7/15, included Prilosec (medication to reduce stomach acid) 20 milligrams (mg) daily. The discharge summary did not include a diagnosis for the medication. The discharge summary also included an order for Trazadone (an antidepressant medication) 50 mg at bedtime as needed for insomnia. An additional order dated 10/8/15, directed the staff to administer Ativan (antianxiety medication) 0.5 mg every four hours as needed for anxiety. The Ativan order also included special instructions to "avoid if delirium present." Review of R5's care plan dated 10/13/15, did not include the above medications. The Medication Administration Record (MAR) for October 2015, indicated R5 had received six doses of Ativan (10/19, 10/22, 10/24, 10/26,	F 329		

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F 329	Continued From page 15 10/27, and 10/30/15). In addition R5 had received two doses of Trazadone (10/9/15 and 10/16/16). R5 had received Prilosec daily. The November 2015, MAR indicated R5 had received three doses of Ativan (11/14, 11/25 and 11/28). R5 had not received Trazadone but had received Prilosec daily. The December 2015, MAR indicated R5 had received Prilosec daily but had not received the as needed medications. The Behavior/Intervention Monthly Flow Records for October 2015, and November 2015, did not indicate R5 had displayed any type of behavior during the months. R5's computerized physician order indicated use GERD (Gastroesophageal Reflux Disease) as the rational/diagnosis for Prilosec. However, R5's clinical record lacked identification of such a diagnosis. On 12/2/15, at 1:50 p.m. the director of nurses (DON) reviewed R5's record. She verified the clinical record lacked a diagnosis of GERD or other justification for R5's continued use of Prilosec. The DON stated GERD was a common diagnosis for Prilosec and whomever transcribed the order from the hospital discharge sheet must have added it to the diagnosis/rational for the medication. She verified R5's record did not include a diagnosis of GERD and lacked continued justification for the medication. -At 2:00 p.m. the DON reviewed R5's Ativan usage. She stated that prior to the administration of an anti-anxiety medication, the staff members were to try alternative interventions prior to the	F 329		

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F 329	Continued From page 16 administration of the medication. She reviewed R5's clinical record and stated the staff identified R5 as being "anxious" prior to giving the medication, but the clinical record lacked non-pharmacological interventions prior to the administration of the medication. She stated the facility should have identified what non-pharmacological interventions had been attempted prior to the administration of the medication. -At 2:05 p.m. the DON reviewed R5's Trazadone usage. The DON indicated R5 had been utilizing Trazodone daily prior to a hospitalization on 10/3/15. Upon return from the hospital the medication had been changed to an as needed medication for sleep. She verified the facility had not reviewed R5's sleeping pattern to determine the continued need for the medication. She stated the facility had not completed a comprehensive assessment for R5's Trazadone nor had they followed up with R5 to determine if she required continued use of the medication. R9 was receiving Trazadone for insomnia and lacked a comprehensive sleep assessment / sleep monitoring and identification of non-pharmacological interventions for sleep prior to the administration of a hypnotic (used for sleep). R9's Face Sheet dated 10/16/15, indicated R9 had diagnoses that included dementia, alcohol dependency (ETOH), adult neglect or abandonment, anxiety and chronic obstructive pulmonary disease (COPD). R9's initial MDS dated 8/17/15, identified R9 had dementia with severe cognitive impairment and required extensive staff assist for dressing and toileting. Section D0200 of the MDS did not indicate R9 had any trouble falling or staying	F 329		

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F 329	Continued From page 17 asleep or sleeping too much. On 12/2/15, at 7:00 a.m. R9 was observed in bed sleeping. Her room was dark. -At 8:30 a.m. observed R9 in the dining room independently eating her breakfast. -At 9:05 a.m. observed R9 in the lounge area watching TV with five other residents. R9's 9/17/15, physician note indicated R9's insomnia was managed well with trazodone. R9's 9/15, 10/15, and 11/15, Consultant Pharmacist's Medication Regimen Review forms indicated "no recommendations." No documentation was noted in the medical record addressing the usage of Trazodone for insomnia. R9's current physician's orders dated 9/14/15, directed staff to administer Trazodone HCL tablet 150 mg by mouth at bed time for sleep. R9's care plan dated 11/16/15, lacked identification of insomnia or monitoring of individualized insomnia symptoms. In addition, the care plan lacked evidence that non-pharmacological approaches were tried before the administration of the medication. R9's care plan indicated R9 used antidepressant medication-trazodone related to anxiety however, the physician wrote the trazodone order for insomnia. On 12/2/15, at 7:20 a.m. licensed practical nurse (LPN)-C, who worked the night shift stated R9 slept thru the night and was not aware of R9 ever having a problem with not sleeping at night. On 12/2/15, at 11:43 a.m. the DON verified R9	F 329		

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F 329	Continued From page 18 was on Trazadone due to not sleeping. The DON stated a sleep study assessment prior the initiation of or after the medication was administered was not completed. The DON also stated there was no documentation or summary note related to the effectiveness or adverse reactions from the medication in R9's medical record. In addition, the DON verified R9's care plan lacked any indication R9 had insomnia, received medication to induce sleep, or identified non pharmalogical interventions to be attempted or signs/symptoms of adverse reactions to be monitored. A policy on conducting sleep studies was requested however, no policy was received. R1 was currently on Prilosec, without a medical diagnosis for usage and was not addressed on the care plan. R1's 9/9/15, quarterly MDS indicated no cognitive impairment and diagnoses included congestive heart failure, anemia and diabetes mellitus. On 12/1/15, at 2:35 p.m. R1 was observed in her room sitting in a chair gathering yarn balls. On 12/2/15, at 8:00 a.m. R1 was observed in her room eating her breakfast independently. At that time, she stated she liked to eat her meals in her room. R1's 5/22/25, physician's orders, indicated Prilosec (medication to reduce stomach acid) delayed release 40 mg daily. On 9/9/15, Pharmacy Consultant note indicated	F 329		

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F 329	Continued From page 19 R1 had a history of a GI bleed and requested a reduction of Prilosec to 20 mg and the nurse practitioner (NP) stated no, R1 was to continue on Prilosec 40 mg. No other recommendations noted on the 10/15, and 11/15 pharmacy consultant monthly reviews. R1's 12/1/15, Medication Administration Record (MAR) indicated Prilosec delayed release 40 mg daily for stomach. R1's printed 12/3/15, care plan did not address the usage of Prilosec. On 12/3/15, at 8:15 a.m. the DON verified R1's medical record lacked a medical diagnosis for the continued use of Prilosec and the usage of Prilosec was not addressed on the care plan. On 12/3/15, at 9:15 a.m. the pharmacy consultant was contacted via telephone and verified the medical record did not include a diagnosis for continued use of Prilosec. The Medication Monitoring and Management Policy dated 11/2011, directed the staff members to ensure all medications were appropriate for the individual resident. The staff were to utilize non-pharmacological interventions before the administration of a new medication or as needed (PRN) medication. The policy indicated if a prescriber deemed a medication necessary, a documented clinical rationale for the benefit of, or necessity for, the medication was documented in the resident's record.	F 329		
F 371	483.35(i) FOOD PROCURE,	F 371		1/8/16

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F 371 SS=F	Continued From page 20 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain sanitary conditions in the kitchen. This practice had the potential to affect all 40 residents residing in the facility. Findings include: On 12/2/15, at 11:00 a.m. the kitchen sanitation tour was completed with certified dietary manager (CDM)/environmental service director. The following areas of concern were identified: - The large can opener affixed to the cooks preparation counter was observed to have a thick layer of debris on the can blade. The can opener mount affixed to the counter top was also observed to be coated in a thick layer of black, sticky debris. The CDM stated the can opener was to be washed daily. She then removed the can opener and placed it in the dirty dish room. - The exhaust hood, located directly above the	F 371	1. The areas identified on the kitchen sanitation tour have been corrected. Large can opener is cleaned daily and continues to be washed daily, exhaust hood has been cleaned as has any debris hanging from the sprinkler system, light is being repaired, and ceiling vent has been cleaned. 2. Dietary staff will be educated prior to 01/05/2015 3. Cleaning schedules have been developed and will be monitored weekly by CDM and or designee for 3 months then monthly thereafter. 4. CDM/Designee will report results and trends of all audits to the QA&A committee for review and follow up as needed. 5. Completion date 01/08/2015	

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F 371	Continued From page 21 stove, was observed to have dust and debris hanging off of the sprinkler system. A thick layer of dust/debris was observed along the outer edge of the hood. The CDM stated the exhaust hood was to be cleaned monthly. - The exhaust hood was also observed to be equipped with five florescent lights. The light directly over the stove was not observed to have a globe. Dust and debris were observed covering the ends of the light fixture. The CDM stated the light above the stove was functioning well, however, when a globe was placed over the light, the heat from the stove rose which caused the globe to melt. She stated the facility had attempted to try alternative globes, but they too had melted. - The ceiling vent next to the stove was observed covered with thick black debris. The CDM verified the vent was in need of cleaning and stated the vents were to be cleaned weekly. The undated Dietary Cleaning Schedule for the 7-11 shift directed staff to clean the can openers daily. In addition, the schedule directed the staff to clean the vents on the first week of the month. The Hood Cleaning policy dated 10/2011, directed the staff to ensure the exhausted hood was cleaned monthly.	F 371		
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly.	F 372		1/8/16

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F 372	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure recyclables were stored within an enclosed refuse container and not on the ground. This practice had the potential to affect all 40 residents residing in the facility, visitors and staff of the facility. Findings include: On 12/2/15, at 11:30 a.m. the refuse system was observed with the director of environmental services. The facility utilized a large dumpster/trash compactor for garbage and three fifty five gallon garbage cans for recycling needs. The recycling cans were observed overflowing with bags of cans, plastic containers and glass products. There were three bags of recycling items on the ground next to the garbage cans. The director of environmental services stated a housekeeper gathered the recycling products once a week and brought them to the community recycling center. She stated the housekeeper was scheduled to empty the recycle items the next day. She verified the garbage cans were overflowing and items to be recycled were stored on the ground. The Waste Disposal policy dated 10/2011, directed staff to place the recycle trash in the outside containers. The policy directed staff to remove the trash from the facility daily, but did not direct the staff to ensure the trash was contained in the outside receptacles.	F 372	1. Recyclables are stored within a refuse container not on the ground. Additional recycling bins have been ordered. 2. Policy and procedure has been reviewed and updated as necessary. Dietary and Environmental staff has been educated related to recycling containment within the receptacles. Area will be monitored bi-weekly for 1 month then weekly for 3 months. Monitoring will be completed by the Environmental Director and or designee. 3. Environmental staff will be educated 01/05/2015 4. Environmental Director/Designee will report results and trends of all audits to the QA&A committee for review and follow up as needed. 5. Completion date 01/08/2015	
F 406	483.45(a) PROVIDE/OBTAIN SPECIALIZED	F 406		1/8/16

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F 406 SS=D	Continued From page 23 REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a level II Preadmission Screening and Resident Review (PASRR) was completed for 1 of 1 resident (R42) who was assessed with intellectual disabilities. Findings include: R42's quarterly Minimum Data Set (MDS) dated 10/05/2015, indicated R42 had moderate cognitive impairment and diagnoses that included mild intellectual disabilities, anxiety disorder and dementia. The MDS also indicated R42 had no mood symptoms, no behavioral symptoms and no psychosis, hallucinations or delusions. The MDS further indicated R42 was independent for bed mobility, transfer, locomotion on and off unit, ambulation and eating, required limited assistance of one for dressing and extensive assistance of one for toileting and personal hygiene. The Pre-Admission Screening Assessment	F 406	1. R42 did have a PASRR Level II completed upon admission to BWCC. The agency that completed the screen was not able to send a copy of this, however they were able to validate that the level II was done and placement in facility is appropriate with no additional services needed. 2. Charts have been reviewed to validate all other residents do have the PASRR Level I and II 3. Running log has been started regarding the PASRR, copies of the PASRR are being kept in file cabinet in the Social Service Designee□s office for access as well as the resident chart. 4. Random charts will be audited monthly to validate PASRR have been completed as well as new admissions will be audited within 24 hours of admission to validate	

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F 406	Continued From page 24 (PAS/OBRA Level 1) dated 4/2/15, indicated a Level II Developmental Disability Evaluation and final review of the need for specialized services was required by placing a check mark next to the statement of such. On 12/02/15 at 11:10 a.m. the activities director (AD) was observed to approach R42 in the television lounge area and asked R42 if she would like to do a word search puzzle. R42 indicated she loved doing them and thanked AD for giving her the puzzle. R42 remained seated in the lounge area drinking coffee and watching television with three other residents. On 12/02/2015, at 1:53 p.m. R42 had remained seated in the lounge area since after lunch watching a movie with 2 other residents. R42 was attentive to the movie, conversed with staff and visitors and was pleasant and smiling. On 12/02/2015, at 1:55 p.m. the social services designee (SSD) indicated the Level II screening for R42 had been completed on 4/9/15, however, he was unable to find it. On 12/03/2015, at 9:35 p.m. the director of nursing (DON) confirmed the level II Pre-Admission Screening and Resident Review should have been completed and available as required. The Pre-Admission Screening for Mental Illness and Retardation (PASSAR) policy dated 4/1/2008, indicated an individual requesting admission to the facility was not admitted with mental retardation, unless prior to admission the state mental retardation or developmental disability authority determined that the physical and mental	F 406	the PASRR is complete. Monitoring will be completed by SSD and or designee. 5. SSD/Designee will report results and trends of all audits to the QA&A committee for review and follow up as needed. 6. Completion date 01/08/2015	

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(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 406	Continued From page 25 condition of the individual required the level of services provided by the facility and the state mental retardation or developmental disability authority determined whether or not the individual required specialized services for mental retardation.	F 406		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental services were provided for an identified dental need for 1 of 1 residents (R9) reviewed who required a dental evaluation. Findings include: R9's Face Sheet dated 10/16/15, indicated R9 was diagnosed with dementia, alcohol dependency (ETOH), adult neglect or abandonment, anxiety and chronic obstructive pulmonary disease (COPD). The Face Sheet also indicated R9 had a guardian responsible for medical and financial matters / concerns.	F 412	1. Dental services are provided for any identified dental needs. R9 has been offered dental services however has refused. Guardian has also been spoken to regarding R9 dentition and has stated it is too traumatic for her and chooses not to send her. R9 also has no complaints of pain or oral discomfort. 2. All residents will continue to be assessed upon admission, quarterly and as needs arise. 3. 2 random charts will be audited 3 times per week for one month then monthly	1/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245138	A. BUILDING _____ B. WING _____	12/03/2015

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F 412	Continued From page 26 R9's initial Minimum Data Set's (MDS) dated 8/17/15, and quarterly MDS dated 10/26/15, had not identified R9's broken or missing teeth. Both MDS's identified R9 was severely cognitively impaired requiring extensive assist with activities of daily living which included oral hygiene. On 12/01/2015, at 10:04 a.m. R9 was observed to have several upper and lower missing teeth. On 12/2/15, at 9:05 a.m. R9 was observed to have missing teeth and when she opened her mouth, the back teeth/molars were black in color. On 12/2/15, at 8:00 a.m. R9 was observed during the breakfast meal. R9 was provided a mechanical soft diet and did not have any trouble eating/chewing the meal which included a pancakes, sausage, donut and juice. A comprehensive oral assessment was not found in R9's medical record. R9's Initial Assessment of all systems dated 8/18/15, indicated R9 had missing teeth. R9's physician note dated 9/17/15, indicated R9 had dementia and poor dentition. The note indicated R9 did have an appointment scheduled in the near future with a dentist, and diet was changed to mechanical soft. R9's dietician note dated 9/21/15, indicated R9 was on mechanical soft textured food diet due to lack of dentition and poor dentition, R9 was able to feed self however, was limited by dementia and anxiety.	F 412	thereafter by SSD and or designee. 4. SSD/Designee will report results and trends of all audits to the QA&A committee for review and follow up as needed. 5. Completion date 01/08/2015	

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F 412	Continued From page 27 R9's nursing note dated 10/26/15, indicated R9 had poor dentition. On 12/2/15, 11:00 a.m. nursing assistant (NA)-D stated R9 required assistance with all of her cares due to dementia. NA-D stated when R9 was handed a toothbrush she stated she did not have any teeth. When staff reminded R9 she still had some teeth left, R9 would brush her teeth. On 12/2/15, at 1:05 a.m. the social worker (SW) stated he was the person in charge of asking residents to go to the dentist. He stated each resident was asked at each care conference if they wanted to see the dentist and R9 had stated no. However, no documentation was noted in R9's medical record regarding dental needs or regarding contacting the guardian regarding R9's dental status. The SW verified R9's missing teeth and refusal to see the dentist was not on her care plan or documented in the medical record. On 12/2/15, at 11:35 a.m. the director of nursing (DON) verified R9 had missing teeth and was in need of dental services. The DON varied R9's refusal of going to the dentist and missing teeth should have been identified on the care plan. The DON confirmed the SW was responsible to address each residents' oral status. On 12/3/15, at 8:10 a.m. the DON stated R9 had a county guardianship and the guardian should have been contacted regarding R9's dental issues. A policy on dental visits was requested however, no policy was received.	F 412		

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F 428	Continued From page 28	F 428		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the licensed pharmacist reported medication irregularities appropriately to the attending physician and the director of nursing to be acted upon for 4 of 6 resident (R42, R5, R9, R1) who would require a report. Findings included: The consultant pharmacist failed to identify concerns with R42's medication regimen related to psychotropic medication use. R42's Admission Record dated 10/16/15, indicated R42 had diagnoses that included mild intellectual disabilities, anxiety, dementia with behavioral disturbance and insomnia.	F 428	1. The Licensed Pharmacist will report medication irregularities to attending physician and DON and will be followed up on. Pharmacy recommendations have been reviewed for R1, R5, R9 and R42 and experienced no negative outcome. 2. Monthly chart audits will be completed, on the days the Pharmacist Consultant is in the building to review residents medication regimen related to psychotropic, anxiolytics, etc., to improve physician response and pharmacist involvement of reporting irregularities in medication regimen. The weekly meetings identified in F329 will also be reviewed with the pharmacist monthly. All resident med have been reviewed for appropriate diagnosis related to the medication. Any medication without appropriate diagnosis has been discontinued or appropriate diagnosis	1/8/16

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F 428	Continued From page 29 R42's quarterly Minimum Data Set (MDS) dated 10/05/15, indicated R42 had moderate cognitive impairment. The MDS indicated R42 experienced no mood symptoms, no psychosis, hallucinations or delusions and exhibited no behavioral symptoms, rejection of care or wandering. The MDS also indicated R42 was independent with bed mobility, transfers, locomotion on and off the unit, ambulation and eating, required limited assistance of one person for dressing and required extensive assistance of one person for toilet use and personal hygiene. The MDS further indicated R42 received antipsychotic and antidepressant medication daily. R42's Psychotropic Drug Use Care Area Assessment (CAA) dated 4/22/15, indicated R42 took a daily antidepressant and antipsychotic for mood disorder. The CAA indicated staff would monitor and consider dose reductions in the future to have R42 at lowest and most effective dose for her quality of life. R42's Medication Review Report dated 10/8/15, identified orders that included but were not limited to Risperdal 1 milligram (mg) by mouth daily in the a.m. for mood with a start date of 4/17/15 and Risperdal 2 mg by mouth at bedtime for mood with a start date of 4/16/15. R42's care plan dated 10/23/15, indicted R42 used psychotropic medications Risperdal and Effexor (antidepressant medication) for anxiety, depression and behavior management. The care plan directed staff to monitor for target behaviors	F 428	obtained. 3. Monitoring will be completed by DON/Admin and or designee. 4. DON/Designee will report results and trends of all audits to the QA&A committee for review and follow up as needed. 5. Completion date 01/08/2015	

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F 428	Continued From page 30 of: 1. mood swings related to depression or episodes with potential of self isolation, not eating or aggressive behavior. The care plan indicated staff was to implement interventions for the target behaviors that included: 1 to 1, redirect, offer activity, encourage to verbalize feelings, calmly ask her to go back to her room. The care plan also directed staff to review target behaviors monthly for trending and effectiveness of interventions. On 12/02/2015, at 7:59 a.m. R42 ambulated independently with a walker to a table in the dining room. R42 greeted fellow residents and smiled. No target behaviors observed. On 12/02/2015, at 8:12 a.m. the director of nursing (DON) brought R42 her medications. The interaction between R42 and DON was cordial. R42 was observed to pour coffee for her tablemate's. No target behaviors were observed. On 12/02/2015, at 11:10 a.m. the activities director (AD) approached R42 in the television lounge area and asked R42 if she would like to do a word search puzzle. R42 indicated she loved doing them and thanked AD for giving her the puzzle. R42 remained seated in the lounge area drinking coffee and watching television with three other residents. No target behaviors observed. On 12/02/2015, at 1:53 p.m. R42 had remained seated in the lounge area since after lunch watching a movie with 2 other residents. R42	F 428		

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F 428	Continued From page 31 was attentive to the movie, conversed with staff and visitors and was pleasant and smiling. No aggressive behavior or other target behaviors observed. Review of R42's Medication Administration Record (MAR) from 9/1/15 through 12/2/15, revealed orders for Risperdal 1 mg by mouth in the am and 2 mg by mouth at bedtime daily for mood. The MAR indicated R42 was administered the medication daily when in the facility. R42's Behavior/Intervention Monthly Flow Record from 10/1/15 through 12/2/15, were reviewed and revealed R42 was monitored for the following target behaviors: mood swings related to depression as manifested by manic or depressive episodes with potential of self isolation, not eating or aggressive behavior. The Flow Records revealed the following behavior history: --10/1/15: Number of behavior episodes: 2. Interventions: redirect, 1 to 1, offered activity, encouraged verbalization of feelings. Outcome: improved. R42's Consultant Pharmacists' Medication Regimen Reviews were reviewed from 5/15/15, to 11/25/15, and revealed the following: --On 5/15/15 the CP's Note to Attending Physician/Prescriber indicated R42 was using Risperdal and requested a documented diagnosis for the use of the medication. --On 6/3/15, the Physician/Prescriber response indicated the information would be obtained from the previous provider if able. The response also	F 428		

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F 428	Continued From page 32 indicated R42 had episodes of agitation and history of aggression. --On 10/20/15, the CP's Note to Attending Physician/Prescriber indicated R42 used Risperdal 1 mg every a.m. and 2 mg every bedtime with doses steady since admission to the facility in May 2015. Please evaluate the appropriateness of a dose reduction in the patient's daily dosage to ensure that the lowest effective dose is being used. If a reduction is not indicated at this time, please document. --On 11/12/15, the Physician/Prescriber response indicated R42 had outbursts at times with the current dose and could be re-directed by staff and would continue with current dose. No further recommendations were made. Review of physician progress notes revealed: --A past clinic visit from a previous provider dated 3/13/15, included chronic problems that included mild mental retardation and dementia and past medical history that included depression. --R42's Nursing Home Note dated 11/24/15, indicated R42 had anxiety under relatively good control and was on Risperdal. The note indicated R42 had a mild tremor in her hands that was likely an essential tremor and the physician would watch for now. The medical record lacked documentation of an indication for the use of Risperdal and documentation of a history of hallucinations, delusions or psychosis. On 12/03/2015 8:30 a.m. nursing assistant (NA)-D stated they monitored R42 for behaviors such as verbal comments or aggression. NA-D	F 428		

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F 428	Continued From page 33 stated when these behaviors occurred, they would redirect R42 and she was usually fine. NA-D stated she didn't think R42 had any delusions, hallucinations or psychosis but to check with the nurse. On 12/03/15, at 9:25 a.m. the DON stated the facility had a difficult time obtaining R42's past medical records to determine an indication for her medication. The DON indicated when the records were received they had included a diagnoses of dementia and at that time the diagnosis of dementia with behavioral disturbance was added to the record for the use of Risperdal. The DON verified there was no documentation in the record of R42 having had any history of hallucinations or delusions and confirmed the diagnosis was not adequate for the continued use of the medication. On 12/03/2015, at 10:20 a.m. the consultant pharmacist (CP) confirmed a request for an indication for the use of Risperdal was requested 5/15/15, and dementia with behavioral disturbance was given. The CP indicated he noted that target behaviors were identified and being monitored but confirmed he did not note the type of behaviors. The CP confirmed he should have recognized the behaviors being monitored were not appropriate for the continued use of anti-psychotic medication. R5 received Prilosec daily and the CP failed to identify the lack of a clinical rationale for it's use. In addition, the CP failed to identify lack of non pharmacological interventions to be attempted or the lack of sleep monitoring related to antianxiety	F 428		

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F 428	Continued From page 34 and antidepressant medication use. R5's quarterly MDS dated 11/13/15, indicated R5 had severe cognitive impairment and diagnoses including osteoporosis and a history of dehydration. During the survey conducted on 11/20/15, from 4:00 p.m. to 8:00 p.m., on 12/1/15, from 8:00 a.m. to 4:30 p.m., on 12/2/15, from 7:00 a.m. to 3:30 p.m. and on 12/3/15, from 8:00 a.m. to 12:00 p.m. R5 was observed to rest in her bed, was fed her meals in bed and received all personal cares in bed. R5's current physician's orders/ Discharge Summary dated 10/7/15, included Prilosec (medication to reduce stomach acid) 20 milligrams (mg) daily. The discharge summary did not include a diagnosis for the medication. The discharge summary also included an order for Trazadone (an antidepressant medication) 50 mg at bedtime as needed for insomnia. An additional order dated 10/8/15, directed the staff to administer Ativan (antianxiety medication) 0.5 mg every for hours as needed for anxiety. The Ativan order also included special instructions to to "avoid if delirium present." Review of the care plan dated 10/13/15, did not include the above medications. The Medication Administration Record (MAR) for October 2015, indicated R5 had received 6 doses	F 428		

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F 428	Continued From page 35	F 428		

of Ativan (10/19, 10/22, 10/24, 10/26, 10/27, and 10/30/15). In addition R5 had received two doses of Trazadone (10/9/15 and 10/16/16). R5 had received Prilosec daily.

The November 2015, MAR indicated R5 had received three doses of Ativan (11/14, 11/25 and 11/28). R5 had not received Trazadone but had received Prilosec daily.

The December 2015, MAR indicated R5 had received Prilosec daily but had not received the as needed medications.

The Behavior/Intervention Monthly Flow Records for October 2015, and November 2015, did not indicate R5 had displayed any type of behavior during the months.

The Consultant Pharmacist Medication Regimen Reviews completed on 10/20/15, and 11/25/15, both indicated no concerns or recommendations.

R5's computerized physician orders revealed a diagnoses of GERD (Gastroesophageal Reflux Disease) as the clinical rationale for the Prilosec use. However, R5's clinical record lacked identification of such a diagnosis.

On 12/2/15, at 1:50 p.m. the DON reviewed R5's record. She verified the clinical record lacked a diagnosis of GERD or other justification for R5's continued use of Prilosec. The DON stated GERD was a common diagnosis for Prilosec and

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F 428	Continued From page 36 whomever transcribed the order from the hospital discharge sheet must have added it to the diagnosis/rational for the medication. She verified R5's record did not include a diagnosis of GERD and lacked continued justification for the medication. -At 2:00 p.m. the DON reviewed R5's Ativan usage. She stated that prior to the administration of an anti-anxiety medication, the staff members were to try alternative interventions prior to the administration of the medication. She reviewed R5's clinical record and stated the staff identified R5 as being "anxious" prior to giving the medication, but the clinical record lacked non-pharmacological interventions prior to the administration of the medication. She stated the facility should have identified what non-pharmacological interventions had been attempted prior to the administration of the medication. -At 2:05 p.m. the DON reviewed R5's Trazadone usage. The DON indicated R5 had been utilizing Trazodone daily prior to a hospitalization on 10/3/15. Upon return from the hospital the medication had been changed to an as needed medication for sleep. She verified the facility had not reviewed R5's sleeping pattern to determine the need for the medication. She stated the facility had not completed a comprehensive assessment for R5's Trazadone nor had they followed up with R5 to determine if she required continued use of the medication. On 12/3/15, at 9:12 a.m. the CP was interviewed via telephone. The pharmacist explained all medications were required to have a current diagnoses to identify what a medication was being utilized for. He stated if the computerized physicians orders had identified GERD as the	F 428		

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F 428	Continued From page 37	F 428		

diagnosis for the use of Prilosec, he would not have looked further into the concern. He stated he was unaware the staff were adding appropriate diagnosis without the residents actually having a diagnosis from a physician. He stated all special instructions from the physician should be transcribed correctly into the electronic clinical record and non-pharmacological interventions should be attempted prior to the administration of antianxiety medication. He verified the facility should be monitoring R5's sleep pattern to determine the continued use of Trazadone. He verified the above concerns should have been identified and indicated on the monthly consultant pharmacy reports.
R9 received Trazadone for sleep and the CP failed to identify the lack of sleep monitoring, non pharmacological interventions to be attempted and clinical justification for the continued use.

R9's Face Sheet dated 10/16/15, indicated R9 was diagnosed with dementia, alcohol dependency (ETOH), adult neglect or abandonment, anxiety, and chronic obstructive pulmonary disease (COPD).

R9's initial MDS dated 8/17/15, and quarterly MDS dated 10/26/15, identified R9 had severe cognitive impairment.

On 12/2/15, at 7:00 a.m. R9 was observed in bed sleeping.
-At 8:00 a.m. observed R9 in the dining room eating her breakfast independently.
-At 9:05 a.m. observed R9 in the lounge area watching TV with five other residents.

On 12/3/15, at 9:00 a.m. observed R9 in the lounge area watching TV with several other

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BOUNDARY WATERS CARE CENTER	**200 WEST CONAN STREET ELY, MN 55731**

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F 428	Continued From page 38 residents. R9's care plan dated 9/17/15, lacked identification of insomnia or monitoring of individualized insomnia symptoms. In addition, the care plan lacked evidence that non-pharmacological approaches were tried before the administration of the medication. R9's current physician's orders dated 9/14/15, directed staff to administer Trazodone HCL tablet 150 mg by mouth at bed time for sleep. R9's care plan dated 10/15/15, indicated Trazadone was being administered for depression and did not include the diagnosis of insomnia. The Consultant Pharmacist Medication Regimen Reviews completed on 9/15, 10/15, and 11/15, indicated no concerns or recommendations. On 12/2/15, at 11:43 a.m. the DON reviewed R9's record. She verified the clinical record lacked a diagnosis of insomnia or other justification for continued usage of trazadone. The DON verified R9 was on Trazadone due to not sleeping. The DON stated a sleep study assessment prior the initiation of or after the medication was administered was not completed. The DON also stated there was no documentation or summary note related to the effectiveness or adverse reactions from the medication in R9's medical record. In addition, the DON verified R9's care plan lacked any indication R9 had insomnia, received medication to induce sleep, non pharmalogical interventions to be attempted or signs/symptoms of adverse reactions to monitor for.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245138	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 39 On 12/3/15, at 9: 30 a.m. the CP was interviewed via telephone. The pharmacist stated all medications were required to have a current diagnoses to identify what a medication was being utilized for. He stated he was unaware of the physicians orders for the usage of Trazadone for insomnia. He stated on R9's care plan indicated usage for depression. He verified the facility should be monitoring R9's sleep pattern to determine the continued use of Trazadone. He verified the above concerns should have been identified and indicated on the monthly consultant pharmacy reports. R1 received Prilosec daily and the CP failed to identify the need for a medical diagnosis for the continued use of the medication. R1's 9/9/15, quarterly MDS indicated no cognitive impairment and diagnosis included congestive heart failure, anemia and diabetes mellitus. On 12/1/15, at 2:35 p.m. R1 was observed in her room sitting in a chair gathering yarn balls. On 12/2/15, at 8:00 a.m. R1 was observed in her room eating her breakfast independently. At that time she stated she liked to eat her meals in her room. R1's 5/22/25, physician's orders, indicated Prilosec delayed release 40 mg daily.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245138	A. BUILDING _____ B. WING _____	12/03/2015

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F 428	Continued From page 40 On 9/9/15, Pharmacy Consultant note indicated R1 had a history of a GI bleed and requested a reduction of Prilosec to 20 mg and the nurse practitioner (NP) response indicated R1 was to continue on Prilosec 40 mg. No other recommendations noted on R1's 10//15, and 11/15, pharmacy consultant monthly reviews. R1's 12/1/15, MAR indicated Prilosec delayed release 40 mg. daily for stomach. R1's care plan dated 12/3/15, did not address the use of Prilosec. On 12/3/15, at 8:15 a.m. the DON verified R1's clinical record lacked a medical diagnosis for the continued use of Prilosec. The DON verified the use of Prilosec was not addressed on the care plan. On 12/3/15, at 9:15 a.m. the CP verified R1's clinical record did not include a diagnosis for the continued use of Prilosec. The CP verified the above concerns should have been identified and indicated on the monthly consultant pharmacy reports. The Consultant Pharmacist Reports policy dated November 2011, directed the consultant pharmacist to complete a monthly medication regimen review for each resident which included but was not limited to reviewing and or evaluating	F 428		

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	245138	A. BUILDING _____ B. WING _____	12/03/2015

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F 428	Continued From page 41 a written diagnosis, indication or documented objective findings supported each medication order. The findings and recommendations from the report were to be communicated to the DON, attending physician and if appropriate to the medical director and/or the administrator.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		1/8/16

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	245138	A. BUILDING _____ B. WING _____	12/03/2015

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F 441	Continued From page 42 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hand hygiene was appropriately performed while providing wound care for 1 of 1 resident (R4) observed during wound care. In addition the facility failed to maintain appropriate infection control technique while transporting resident clothing and storage of the dirty linen cart within the laundry room. Findings include: R4 was observed to receive wound care and the nurse failed to perform appropriate handwashing. On 12/02/2015, at 11:21 p.m. licensed practical nurse (LPN)-B was observed to gather wound care supplies, enter R4's room and wash her hands. LPN-B assisted R4 to stand and lower her pants. LPN-B assisted R4 to bed and positioned her on her left side. LPN-B removed R4's incontinence brief and discarded the brief, removed and discarded her gloves and immediately donned clean gloves. LPN-B removed the old dressing and wound packing from R4's coccyx wound. LPN-B discarded her gloves and donned a clean pair of gloves without first performing hand hygiene. LPN-B measured the wound, wet a 4 x 4 gauze with saline and dabbed the surface of the wound. LPN-B	F 441	1. Licensed Nurses have been educated regarding hand washing with wound care. Laundry/Environmental Services have been educated regarding techniques while transporting residents clothing and storage of dirty linen carts with in the laundry room to maintain appropriate infection control. Policy for linen handling has been reviewed and updated as appropriate. 2. Audits will be completed 3 times per week for one month then 1 time per week for three months 3. Monitoring for handwashing by observation will be completed by DON and or designee during wound care, monitoring for linen handling will be completed by Environmental/Laundry Director and or designee. 4. Results from the audits will be presented at the QA&A committee for review by DON/designee and Environmental/Laundry Director 5. Completion date 01/08/2015	

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	245138	A. BUILDING _____ B. WING _____	12/03/2015

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F 441	Continued From page 43	F 441		

removed her gloves and immediately donned clean gloves without performing hand hygiene. LPN-B packed the wound with one 2 x 2 gauze pad soaked with normal saline using a sterile swab. LPN-B applied clotrimaloze cream (antifungal) to the skin surrounding the wound. LPN-B removed and discarded her gloves and immediately donned clean gloves. LPN-B proceeded to tape a 4 x 4 gauze over the wound. LPN-B changed her gloves, apply an incontinent brief on R4 and raised her pants. LPN-B discarded her gloves and washed her hands.

On 12/02/2015, at 11:45 a.m. LPN-B confirmed she changed her gloves and did not wash her hands between removing R4's soiled dressing and applying the clean dressing.

On 12/03/2015, at 9:33 a.m. the director of nursing (DON) confirmed hand hygiene should have been performed between the removal of the soiled dressing and application of the clean dressing.

The Bandages policy dated April 2009, directed staff to wash hands and put on new gloves prior to removal of the old dressing. The policy directed staff to remove the old dressing, put soiled dressing in appropriate bag for disposal, remove gloves, wash hands/sanitize, put on new gloves and apply appropriate bandage.

Laundry:

On 12/2/15, at 10:00 a.m. the activity director was observed pushing a long, rolling, hanging clothes rack that was full of resident's clothes from the

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	245138	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOUNDARY WATERS CARE CENTER	**200 WEST CONAN STREET ELY, MN 55731**

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F 441	Continued From page 44 laundry room out to the floor. The rack was not covered. On 12/2/15, at 3:00 p.m. three large red containers on rolling wheels was observed in the clean section of the laundry room. A large bin which contained clean resident clothing protectors, a two wheeled hanging resident clothes rack and one additional hanging rack which was filled with resident clean clothing items was observed next to the three red containers. On 12/3/15, at 7:45 a.m. housekeeper-A stated the large red rolling containers were used for collecting dirty clothes from the floor. He stated the dirty clothes were picked up from the floor, wheeled to the laundry room and brought into the dirty section of the laundry room. The dirty laundry was then transferred into bins which were picked up by the laundry service the agency used for cleaning their laundry. At 8:00 a.m. the supervisor for environmental services and dietary verified the large red carts were used to collect the facility's dirty laundry and were stored in the clean section of the laundry room. She also verified the long rolling clothing rack was not covered during transport and should have been. The supervisor stated the agency would start placing the three large red bins in the dirty section of the laundry room and would start covering the clothing racks during transport. A policy on linens-handling dated 4/1/12008, was received however, the policy did not address the storage of bins or the transport of clothing.	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL	F 465		1/8/16

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	245138	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 465	Continued From page 45 E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the kitchen floor was maintained in a safe, cleanable condition. This practice had the potential to affect all 40 residents in the facility. Findings include: On 12/2/15, at 11:00 a.m. the kitchen sanitation tour was completed with certified dietary manager (CDM) / environmental service director. The following areas of concern were identified: - The ramp leading into the exterior walk in cooler/freezer was observed to be a cement incline. The paint on the floor had worn off exposing the bare cement creating an uncleanable surface. - The dry storage area was observed on right side of the kitchen. The area was observed to have a cement painted floor. The paint was worn off which left the bare uncleanable cement exposed. - The main kitchen floor was covered with tile. The grout between the tile was observed blackened with scattered debris. Debris build up was observed next to the kitchen fixtures and along the edge of the walls.	F 465	1. Maintenance request has been submitted and will be completed by 01/08/2016 to paint areas identified, fix tile around drain, the grout used on the tile floor is black in color, and cleaning schedule has been developed and implemented. 2. Floor safety policy was reviewed and staff have been educated regarding policy and procedure 3. Cleaning schedules have been developed and will be monitored weekly by CDM and or designee for 3 months then monthly thereafter. 4. CDM/Designee will report results and trends of all audits to the QA&A committee for review and follow up as needed. 5. Completion date 01/08/2015	

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	245138	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 465	Continued From page 46 - A floor drain in front of the dry storage area was observed to have broken tiles surrounding the drain. On 12/2/15, at 11:35 a.m. the CDM verified the floor was in need of cleaning and repair. She stated she was working on scheduling a staff member to clean the floors with a floor scrubber once a month, but a schedule had not yet been established. The Floor Safety policy dated 10/11/11, directed staff to ensure the floor was maintained in a safe manner. Any concerns with the floor were to be reported to the hospital plant services department for repair.	F 465		

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	245138	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/03/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOUNDARY WATERS CARE CENTER	**200 WEST CONAN STREET** **ELY, MN 55731**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Boundary Waters Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR Or by email to:	K 000	EPOC	

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

Electronically Signed | 12/22/2015

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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	245138	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/03/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOUNDARY WATERS CARE CENTER	**200 WEST CONAN STREET** **ELY, MN 55731**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Boundary Waters Care Center is a 1-story building with no basement. The building was constructed in 1968, with an addition in 2002. Both buildings are of Type II(111) construction, therefore the building was inspected as one building. The building has an automatic sprinkler system installed throughout in accordance with NFPA 13 Standard for Installation of Automatic Sprinkler Systems (1999 edition). The facility has a fire alarm system with smoke detection throughout the corridor system and in the common spaces. The fire alarm system is monitored for automatic fire department notification and is installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition).	K 000		

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	245138	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/03/2015**

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BOUNDARY WATERS CARE CENTER	**200 WEST CONAN STREET** **ELY, MN 55731**

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K 000	Continued From page 2 The facility has a capacity of 40 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 1 fire separations was found not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1 and 19.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect the residents, staff and visitors of the facility. Findings include: On facility tour between 12:30 AM to 3:30 PM on 12/03/2015, observations revealed that the following deficient conditions were found affecting the facility's 2 hour fire separations: 1. there was a 1/4 inch gap found between the double doors in the 2 hour fire separation located	K 011	1. Gap between the double doors located between the hospital and care center was repaired 12/09/2015, the 2 openings around the electrical flex conduit and the 3 penetrations were also repaired 12/16/2015 by Plant Services. 2. Completion dates 12/09/2015 and 12/16/2015 3. Plant Services Director is responsible for the correction and monitoring.	1/8/16

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	245138	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/03/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOUNDARY WATERS CARE CENTER	**200 WEST CONAN STREET** **ELY, MN 55731**

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K 011	Continued From page 3 between the hospital and the care center, 2. there are 2 opening around electrical flex conduit located above the ceiling tile located in the 2 hour fire wall separating the hospital and the care center, and 3. there were 3 penetrations around conduit that is located in the 2 hour fire wall by the elevator separating the hospital from the care center. This deficient condition was verified by the Plant Maintenance Manager (AF).	K 011		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with	K 056	1. Sprinkler heads that were identified on Blueberry Hill have been corrected and there is no longer two different types in	12/9/15

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	245138	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/03/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOUNDARY WATERS CARE CENTER	**200 WEST CONAN STREET** **ELY, MN 55731**

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K 056	Continued From page 4 NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 12:30 AM to 3:30 PM on 12/03/2015, observations have revealed that there are 7 standard type of sprinkler heads mixed in with quick response sprinkler heads located in the Blueberry Hill wing. This situation has combined two different type of sprinkler heads with in the same compartment. This deficient condition was verified by the Plant Maintenance Manager (AF).	K 056	the same compartment. 2. Summit Fire Protection completed this on 12/09/2015 3. Plant Services Director is responsible for the correction and monitoring.	
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom	K 067	1. Documentation of Smoke Damper Test will be completed. 2. Completion date 01/08/2016	1/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245138	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/03/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOUNDARY WATERS CARE CENTER	**200 WEST CONAN STREET** **ELY, MN 55731**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 5 exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: On facility tour between 12:30 AM to 3:30 PM on 12/03/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and interview with the Plant Maintenance Manager (AF), that the facility could not provide any documentation for the smoke and fire damper testing at the time of the inspection. This deficient condition was verified by the Plant Maintenance Manager (AF).	K 067	3. Plant Services Director is responsible for the correction and monitoring.	