

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 12, 2022

Administrator Boundary Waters Care Center 200 West Conan Street Ely, MN 55731

RE: CCN: 245138

Cycle Start Date: March 10, 2022

Dear Administrator:

On March 22, 2022, we notified you a remedy was imposed. On April 14, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 8, 2022.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective April 6, 2022 be discontinued as of April 8, 2022. (42 CFR 488.417 (b))

In our letter of March 22, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 6, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 8, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst Minnesota Department of Health

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 12, 2022

Administrator Boundary Waters Care Center 200 West Conan Street Ely, MN 55731

Re: Reinspection Results

Event ID: 07UP12

Dear Administrator:

On April 14, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 18, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst Minnesota Department of Health

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted March 22, 2022

Administrator Boundary Waters Care Center 200 West Conan Street Ely, MN 55731

RE: CCN: 245138

Cycle Start Date: March 10, 2022

Dear Administrator:

On March 10, 2022, survey was completed at your facility by the Minnesota Department 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. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On March 9, 2022, the situation of immediate jeopardy to potential health and safety cited at F 886 was removed. However, continued non-compliance remains at the lower scope and severity of F.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 6, 2022.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 6, 2022, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 6, 2022, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 6, 2022. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the
 deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" and/ or "E" tag), i.e., the plan of correction should be directed to:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900

Email: susan.frericks@state.mn.us

Mobile: (218) 368-4467

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 September 10, 2022 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter.

Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor Deputy State Fire Marshal

> Health Care/Corrections Supervisor – Interim Minnesota Department of Public Safety 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145

Cell: (507) 361-6204

Email: william.abderhalden@state.mn.us

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

PRINTED: 05/17/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,	l ` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/31/2022

Electronically Signed

program participation.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (2		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 609	procedures. §483.12(c)(4) Report investigations to the designated repressed accordance with St Survey Agency, with incident, and if the appropriate correct This REQUIREMED by: Based on interview facility failed to report to the State Agency regulations for 1 of abuse. Findings include: R20's quarterly Min 1/22/22, indicated Included Parkinson diabetes. R20 had and required exten activities of daily lived R20's care plan with indicated he requires staff with dressing, mobility and transfermechanical stand windicated an individual because R20 had included verbal and were to monitor for interdisciplinary teacare plan as needed.	ort the results of all e administrator or his or her entative and to other officials in tate law, including to the State hin 5 working days of the alleged violation is verified live action must be taken. NT is not met as evidenced or and document review, the ort bruising of unknown origin of (SA) according to Federal 1 residents (R20) reviewed for himum Data Set (MDS) dated R20 had diagnoses that lis disease, dementia, and severe cognitive impairment sive assistance to complete alleging (ADLs). The revision date of 11/29/21, and assistance of one to two grooming, toileting, bed assistance of one to two grooming, toileting, bed ares. Staff were to use a with transfers. The care plan lural abuse prevention plan moments of aggression that disphysical towards staff. Staff all injuries and discuss in the am meetings (IDT) and adjust	F 609	Immediate Corrective Action A root cause analysis was of identify contributing factors the break in facility policy are implementation of interventing a recurrence. Corrective Action as it Applit The Abuse prevention policy procedure was reviewed an current. The IDT and facility staff will on the Abuse Prevention Porreporting of alleged violation. Prevent Recurrence: Incidents will be reported in with facility policy for abuse During daily clinical meeting be reviewed by the IDT to ereporting requirements have based on the nature of the aviolation. Date Certain: April 8, 2022 Ongoing Monitoring: Incident report audits will be	ompleted to which caused and to aid in the ons to prevent es to Others: y and d remains I be educated blicy regarding as. accordance prevention. I, incidents will a been met alleged		

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F 609	reported to register report from night so R20's left temple accentimeters in size know he had a brubruise occurred. If director of nursing R20's physician has R20's progress not seven by nine cert R20's left temple, had happened. R26 further documental During joint intervit (DON) and the as (ADON) on 3/9/22 resident falls and any changes would meetings. The ID cause of the injury documented in the probable cause are remember R20 has temple and had the thought maybe he against the side of indicated R20's bruto the SA and a rewas not. The DON find any further for R20's medical recommended in the side of indicated R20's bruto the SA and a rewas not. The DON find any further for R20's medical recommended in the side of indicated R20's bruto the SA and a rewas not. The DON find any further for R20's medical recommended in the side of indicated R20's bruto the SA and a rewas not. The DON find any further for R20's medical recommended in the side of indicated R20's bruto the SA and a rewas not. The DON find any further for R20's medical recommended in the side of t	I sustained a bruise which was bred nurse (RN)-A during shift shift. The bruise was located on and measured seven by nine e. R20 had stated he did not uise. It was unknown how the he incident report indicated the (DON), the administrator and ad been notified of the injury. Set dated 11/13/21, identified a atimeter bruise was located on R20 was unable to report what 20's progress notes lacked any ation related to the bruise. Sew with the director of nursing sistant director of nursing sistant director of nursing sistant director of nursing and the discussed in the daily IDT of would try to determine the the resident's progress notes the notate about the solution. She did and sustained a bruise to his left tought it was odd. They had a had drooped his head and hit it for the should have been filed; but a lindicated he was unable to allow up with the incident in	F6	el aar pp ww - - - A ree mree	nsure alleged violations were accordance with facility policy a rocedures for abuse preventional ill be completed as follows: 5 times per week X 2 weeks 2 times per week X 2 weeks Weekly X 4 weeks Summary of audit results will eviewed during the monthly Queeting for the next 60 days for ecommendations. Ionitored By: xecutive Director or designee	and on. Audits be API or further		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	or possibly could halift during a transfer an investigation was management when they would address process. They did neetings, so nothin R20's bruise investi was to report injurie not determine the cin a suspicious area R20's bruise was nothought to have occipanel or the mecha. The facility policy Frand Exploitation, dainjury of unknown sobserved by any peexplained by the resuspicious because the location of the in incidents of possible suspicious bruising identified and the accordance with states.	h his high backed wheel chair ave been from the mechanical. The administrator indicated is done through risk a bruise or fall occurred and those through the IDT not record minutes for the SA when they cold ause, if it was a major injury or a. The administrator indicated by his wheel chair side nical lift during a transfer. Treedom From Abuse, Neglect, ated May 2020, defined an ource when it was not not reson, the injury could not be sident and the injury was not not reson, the injury could not be not resident and the injury or not plury. The policy indicated a buse or neglect, such as not residents would be diministrator, DON or designee propriate regulatory, a enforcement agencies in not regulations.	F 60			
	CFR(s): 483.12(c)(2) §483.12(c) In respondent, exploitation must:	ense to allegations of abuse, in, or mistreatment, the facility evidence that all alleged	F 61	U		4/8/22
	violations are thoro	ughly investigated.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION (X:	(X3) DATE SURVEY COMPLETED C		
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F 610	S483.12(c)(3) Previneglect, exploitation investigation is in psubassistic structure of the second and structure of	ent further potential abuse, in, or mistreatment while the progress. Out the results of all the administrator or his or her entative and to other officials in that law, including to the State thin 5 working days of the alleged violation is verified tive action must be taken. Now I is not met as evidenced and document review, the roughly investigate bruising of 1 of 1 residents (R20) in the state of 1 of 1 residents (R20) in the state of 1 of 2 of 3	F 610	Immediate Corrective Action: A root cause analysis was completed identify contributing factors which cau the break in facility policy and to aid in implementation of interventions to pre a recurrence. Corrective Action as it Applies to Othe The Abuse prevention policy and procedure was reviewed and remains current. The IDT and facility staff will be education the Abuse Prevention Policy regard	to sed the event ers:	
	indicated he require staff with dressing, mobility and transfer mechanical stand videntified an individent to R20 had moment physical towards stand videntified and moment physical towards standards.	th revision date of 11/29/21, ed assistance of one to two grooming, toileting, bed ers. Staff were to use a with transfers. The care plan lual abuse prevention plan due ats of aggression, verbal and eaff. Staff were to monitor for cuss in IDT and adjust care		the investigation, prevention, and correction of alleged violations. Prevent Recurrence: Alleged violations will be investigated documented in accordance with facilit policy. Documentation of the alleged violation will be reviewed by the IDT a Date Certain: April 8, 2022 Ongoing Monitoring:	У	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
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F 610	On 11/13/21, at 7:0 identified R20 had reported to register report from night sh R20's left temple at centimeters in size know he had a bruibruise occurred. The director of nursing R20's physician had R20's progress not seven by nine cent R20's left temple. Fhad happened. R20 further assessment R20's medical recomposition of his During joint intervied (DON) and the ass (ADON) on 3/9/22, resident falls and be any changes, they interdisciplinary team would try to determ and if able, it would resident's progress the solution. She disustained a bruise thought it was odd. had drooped his he of his wheelchair. To "found" the cause of bumping his head of The DON was unal investigation, follow	on a.m. an incident report sustained a bruise which was led nurse (RN)-A during shift wift. The bruise was located on a measured seven by nine and R20 had stated he did not see. It was unknown how the me incident report indicated the (DON), the administrator and did been notified of the injury. The dated 11/13/21, identified a simeter bruise was located on R20 was unable to report what D's progress notes lacked any to related to the bruise. The dated documentation of bruise of unknown origin. The with the director of nursing istant director of nursing at 1:26 p.m. the ADON stated ruises were documented and if would be discussed in the daily meetings (IDT). The IDT into the the cause of the injury libe documented in the notes the probable cause and different remember R20 had to his left temple and had They had thought maybe he had and hit it against the side of the injury to be from R20 on the side of his wheel chair. The lated to the incident or frelated to the inc	F 6	310	Audits will be completed to ensure violations are investigated and according to facility policy and procedures for prevention. Audits will be completed follows: - 5 times per week X 2 weeks - 2 times per week X 2 weeks - Weekly X 4 weeks A Summary of audit results will be reviewed during the monthly QAPI meeting for the next 60 days for fur recommendations. Monitored By: DON or designee	ording abuse d as	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
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F 610	When interviewed of administrator stated discussed R20's bright was proposed the interviewed of panel of or possibly could hall fit during a transfer there was no format and nothing had be administrator indicated done through risk in fall occurred and the through the IDT prominutes for the IDT documented related. The facility policy Fand Exploitation, daincidents of possible suspicious bruising identified. Allegation thoroughly investigated allegation. The adricomplete the investigation of the could include but with the resident involve incident, the circumincident, where the	on 3/10/22, at 1:58 p.m. the d he remembered they had uise during an IDT meeting. It njury may have been caused in his high backed wheel chair ave been from the mechanical interest. The administrator confirmed all investigation of the incident are documented. The ated an investigation would be management when a bruise or ey would address those ocess. They did not record in meetings, so nothing was did to R20's bruise investigation. Treedom From Abuse, Neglect, ated May 2020, indicated a abuse or neglect, such as of residents would be ated upon receipt of the ministrator or designee would tigation process. Investigation as not limited to the name of ad, the date and time of the incident took place, names of the person(s) alleged with	F6	10		
	Baseline Care Plan CFR(s): 483.21(a)(F 6	55		4/8/22
	Planning §483.21(a) Baselin	ensive Person-Centered Care e Care Plans facility must develop and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCT NG	COM	(X3) DATE SURVEY COMPLETED		
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F 655	that includes the inseffective and persor that meet profession. The baseline care profession. The baseline care profession. The baseline care profession. (ii) Be developed with admission. (iii) Include the minimal profession order. (C) Dietary orders. (D) Therapy services. (E) Social services. (E) Social services. (F) PASARR recommodification of the comprehensive care plan if the comprehensive care plan if the comprehensive care plan if the comprehension. (ii) Meets the require (b) of this section (c) this section).	ne care plan for each resident structions needed to provide n-centered care of the resident nal standards of quality care. plan mustithin 48 hours of a resident's mum healthcare information rly care for a resident nited toed on admission orders. St. In mendation, if applicable. Facility may develop a replan in place of the baseline apprehensive care planhin 48 hours of the resident's rements set forth in paragraph excepting paragraph (b)(2)(i) of facility must provide the representative with a summary plan that includes but is not of the resident. The resident's medications and and treatments to be a facility and personnel acting	F 6	55			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 655	This REQUIREMEI by: Based on interview facility failed to devensure immediate and addressed for reviewed for comprise admissions. Findings include: R231's admit tool in 3/3/22, for chronic (COPD). R231's electronic in paper chart lacked plan. During an interview assistant director obaseline care plan admission and was direct the initial planchecked R231's EN a baseline care plan should have been. R17's undated Admission and was admitted to the diagnoses including heart beat), hypertekidney disease and clostridium difficile large colon). R17's admission M1/11/22, indicated significant and mission M1/11/22, indicated significant significant and mission M1/11/22, indicated significant significa	age 12 NT is not met as evidenced of and document review, the relop a baseline care plan to resident needs were identified 2 of 3 residents (R231, R17) rehensive care planning and rehensive care planning and redicated an admission date of obstructive pulmonary disease needical record (EMR) and evidence of a baseline care on 3/10/22, at 8:17 a.m. the finursing (ADON) stated the was to be done upon a important because it would not care for R231. The ADON MR and paper chart and stated in was not done for R231 and resion Record indicated she a facility on 1/4/22, with gratrial fibrillation (irregular ension, difficulty walking, it enterocolitis due to (C. Diff) (an infection in the linimum Data Set (MDS) dated she was cognitively intact and all behavior symptoms not	F 65:	Immediate Corrective Action: Baseline care plans were deveresidents R231, and R17. Corrective Action as it Applies An audit will be completed to e resident has a resident-center care plan or comprehensive care place of the baseline care plan Residents without a baseline comprehensive care plan will he developed based on the finding facility audit. Prevent Recurrence: The policy and procedure for compasseline care plans was review remains current. Licensed nursing staff will be eather policy to ensure individuality centered care plans are developed as hours of admission. Date Certain: April 8, 2022 Ongoing Monitoring: Audits will be completed follow admission to ensure baseline of are completed in accordance of policy and procedures. Audits completed as follows: 5 times per week X 2 weeks 2 times per week X 2 weeks Weekly X 4 weeks A Summary of audit results will reviewed during the monthly Q	to Others: ensure each ed baseline are plan in nave one gs of the developing wed and educated on zed resident oped within ving care plans with facility will be	

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F 655	Continued From pa	ge 13	F 6	55			
	incontinent of bowe extensive assistant living (ADLs).	ers. R17 was frequently I and bladder and required se with all activities of daily			meeting for the next 60 days for fur recommendations. Monitored By: DON or designee	ther	
	any evidence a bas developed to ensur R17's care needs, of infection and needs	rd was reviewed and lacked eline care plan had been e staff were knowledgeable in despite R17 having a C. Diff for special infection control at the spread of the infection to staff.					
	assistant director of R17's medical reco baseline care plan. should have comple ensure staff were in	on 3/10/22, at 10:25 a.m. the f nursing (ADON) reviewed rd and verified the lack of a The ADON stated nursing eted the baseline care plan to astructed in R17's care needs w how to care for her.					
F 656 SS=D	Plan policy dated M residents would have included the instruction effective and person resident that meet pullity care. The bar developed and implication within 48 hours of a	Comprehensive Care Plan	F 6	56			4/8/22
	§483.21(b)(1) The fimplement a compricate plan for each r	chensive Care Plans facility must develop and ehensive person-centered resident, consistent with the orth at §483.10(c)(2) and					

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objectives medical, redical, redical, redical, redical, redical, redical, redical, redical, required to (ii) The second of the provided of the	s)(3), that and time and time and time and time and time and tare ider ent. The content and the follow rices that ander §48 ervices that ander §48 ervices that and the residue to the and tions. If the PAS and the resident's putcomes, esident's putcomes, esident's putcomes, esident's putcomes. For the resident's putcomes and the resident's putcomes are resident's putcomes. Enter the resident's putcomes and the resident's putcomes and the resident's putcomes. Enter the resident's putcomes and the resident's putcomes are resident's putcomes and the resident's putcomes are the resident's putcomes and the resident and the reside	includes measurable eframes to meet a resident's and mental and psychosocial attified in the comprehensive comprehensive care plan musting - at are to be furnished to attain ident's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required as 3.25 or §483.40 but are not a resident's exercise of rights luding the right to refuse 83.10(c)(6). It services or specialized the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. With the resident and the attative(s)-goals for admission and coreference and potential for acilities must document ant's desire to return to the sessed and any referrals to sies and/or other appropriate	F 6	556	Immediate Corrective Action:		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 656	Continued From predented comprehand included interresident symptom potential for declinand/or treatment is shortening of a more residents (R20, Rare plans). Findings include: R20's undated Ad had diagnoses of and diabetes. R20's quarterly More 1/22/22, indicated impairment and rewith all activities of impaired range of his upper extremitive R20's ADL Care Aoriginative resistance with all was at risk for corimmobility. Continuosility each shift to avoid complicated disciplines was not residented.	page 15 nensive plan of care identified eventions to assess and treat is related to their diagnoses, ne, addressed care needs for contractures (a permanent fuscle or joint) for 2 of 13 10) reviewed for comprehensive mission Record indicated R20 Parkinson's disease, dementia, inimum Data Set (MDS) dated R20 had severe cognitive equired extensive assistance of daily living (ADLs). R20 had motion (ROM) on one side on the and did not ambulate. Area Assessment (CAA) dated R20 required extensive I ADLs. The CAA identified R20 intractures as a complication of found staff assist with ADLs and it would be care planned in order tions and referrals to others of warranted. Existing	F 6		plan for R20 was reviewed and upon include additional information regared R20 selft hand contracture and protector. The person-centered comprehensing plan for R10 was reviewed and upon include information regarding R10 sedema, pain, pressure ulcer risk, at ADLS. Corrective Action as it Applies to OAn audit will be completed to ensur comprehensive care plans are devisor other residents with limited ROI edema, pressure ulcer risk, and AD dependency. Person centered care plans will be updated, as needed, audit to ensur plans are comprehensive based or facility audit. Prevent Recurrence: The policy and procedure for comprehensive care plans was revand remains current. Licensed nursing staff will be educate policy. Date Certain: April 8, 2022	dated to rding alm ve care dated to s ind thers: re eloped M, pain, DL re care in the	
	R20's care plan la R20 had Parkinso encourage exercis report any improv physician. The ca limited physical m	e not identified on the CAA. ast revised 11/29/21, indicated on's disease and directed staff to se and mobility. Staff were to ement or decline to the are plan also identified R20 had obility related to his Parkinson's entia. Staff were directed to			Ongoing Monitoring: Audits will be completed following admission to ensure baseline care are completed in accordance with policy and procedures. Audits will be completed as follows: - 5 times per week X 2 weeks - 2 times per week X 2 weeks - Weekly X 4 weeks	facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED C	
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F 656	monitor and documinmobility, contract and skin breakdow identification R20 h hand, as well as int guard in R20's left I assistant (NA) care direction for use of On 3/9/22, at 3:37 g a.m. R20 was obsewith a palm protect. During interview on occupational therap was not aware R20 not been initiated b OTA-A felt it must h intervention. She diprotector had been When interviewed assistant director of had implemented the but was unsure who initiated. During interview on director of nursing inter	nent signs and symptoms of tures forming or worsening in. The care plan lacked and a contracture to his left terventions of placing a palm hand. In addition, the nursing is sheet dated 1/3/22, lacked a palm protector. p.m. and on 3/10/22, at 8:20 erved sitting in his wheel chair or in place in his left hand. 1.3/10/22, at 10:15 a.m. post aide (OTA)-A stated she is used a palm protector. It had by Occupational Therapy and have been a nursing did not know when the palm implemented. 1.3/9/22, at 1:26 p.m. finursing (ADON) stated they he sheepskin palm protector en the intervention was 1.3/9/22, at 2:54 p.m. the (DON) stated R20's care plan erventions to treat R20's eft hand and the care plan and build have been updated to he palm protector. 1.3 are Plan conference was an ocess and provided an in-depth in the care plan conference was an ocess and provided an in-depth	F6	656	A Summary of audit results will be reviewed during the monthly QAPI meeting for the next 60 days for furecommendations. Monitored By: DON or designee	rther	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
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F 656	R10's Admission Ridentified diagnoses Mellitus, chronic diacondition in which tas well as it should spinal stenosis (a column narrows puthe spinal column), right upper extremit disease in at least 1 pain, restricted moves R10's admission M1/20/22, indicated Fadequate vision and assistance with AD of bowel and bladdomedications in the for developing press R10's Care Area As 1/20/22, triggered proposition (physical immobility and pressure ulcer/indicated the facility areas. R10's care plan initindicate potential condicated the facility areas. R10's care plan initindicate potential condicated to lumb polyosteoarthritis, a his need for assistated to development of the nursing assistated.	ecord printed 3/10/22, so that included Diabetes astolic heart failure (a chronic he heart doesn't pump blood), morbid obesity, lumbar condition in which the spinal titing pressure on the nerves in carpal tunnel syndrome of the ty, and polyosteoarthritis (joint five joints with inflammation, wement, and swelling). Inimum Data Set (MDS) dated R10 was cognitively intact, had doesning, required extensive Ls, was frequently incontinent ter, was on scheduled pain past five days, and was at risk sure ulcers. Resessment (CAA) dated cotential for ADL decline (y), urinary incontinence, falls, finjury. The analysis of findings y would care plan in these diated on 1/22/22, did not concerns related to R10's heart failure and edema, his par spinal stenosis, and carpal tunnel syndrome, ance with ADLs, or his potential	F6	56			

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OVIDER OR SUPPLIER Y WATERS CARE C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONAN STREET ELY, MN 55731	1 00/	10/2022
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at 10's Braden skin an easure risk of skin an easure risk of skin and icated R10 score ummary was as for eakdown. Can on and incontinent of both 10's physician processor with a feet. Mild edem at remities. On 3/7/22, at 3:21 pecliner and stated lon 3/8/22, at 1:47 pecliner and complanting. On 3/10/22, at 1:47 pecliner and complanting.	assessment (a tool to impairment) dated 1/14/22, and 16 (mild risk). The allows: at risk for skin ly make slight movements ladder. gress note dated 2/28/22, at R10's only complaint was the the neuropathy in his hands a was noted in R10's a.m. R10 was seated in his ine had pain in his hands. b.m. R10 was seated in his ined of his feet and hands p.m. the director of nursing care plan lacked or interventions for edema, is, and ADLs. The DON is responsible for completing sidents care plan was	F 65	56		
ndicated the care p e quarterly and as n-depth review of th care Plan Timing an FR(s): 483.21(b)(2	lan review/conference would needed and would provide an ne resident's plan of care. nd Revision 2)(i)-(iii)	F 6	57		4/8/22
	SUMMARY STATE CACH DEFICIENCY REGULATORY OR LS Continued From page 10's Braden skin and assure risk of skin and incontinent of both and incontinent o	ATTIGENTIFICATION NUMBER: 245138 DVIDER OR SUPPLIER Y WATERS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 18 ATO'S Braden skin assessment (a tool to neasure risk of skin impairment) dated 1/14/22, adicated R10 scored 16 (mild risk). The number was as follows: at risk for skin reakdown. Can only make slight movements and incontinent of bladder. ATO'S physician progress note dated 2/28/22, at an an indicated R10's only complaint was the thronic issues with the neuropathy in his hands and feet. Mild edema was noted in R10's extremities. AND 3/7/22, at 3:21 p.m. R10 was seated in his ecliner and stated he had pain in his hands. AND 3/8/22, at 1:47 p.m. R10 was seated in his ecliner and complained of his feet and hands aurting. AND 3/10/22, at 1:13 p.m. the director of nursing DON) stated R10's care plan lacked lentification, goals, or interventions for edema, and, pressure ulcers, and ADLs. The DON erified nursing was responsible for completing and ensuring the residents care plan was	A BUILDIN BENTIFICATION NUMBER: 245138 DVIDER OR SUPPLIER Y WATERS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Fontinued From page 18 Continued From page 18 Continued R10's cored 16 (mild risk). The ummary was as follows: at risk for skin reakdown. Can only make slight movements and incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's only complaint was the hard incontinent of bladder. Continued R10's R10's only complaint was the hard incontinent of bladder. Continued R10's R10'	DVIDER OR SUPPLIER 245138 DVIDER OR SUPPLIER WATERS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR I.S. DIENTIFYING INFORMATION) FONTINUE From page 18 10's Braden skin assessment (a tool to leasure risk of skin impairment) dated 1/14/22, dicated R10 scored 16 (mild risk). The ummary was as follows: at risk for skin reakdown. Can only make slight movements and incontinent of bladder. 10's physician progress note dated 2/28/22, at 240 a.m. indicated R10's only complaint was the bronic issues with the neuropathy in his hands and feet. Mild edema was noted in R10's xtremities. 10'n 3/8/22, at 1:47 p.m. R10 was seated in his ecliner and stated he had pain in his hands. 10'n 3/8/22, at 1:47 p.m. R10 was seated in his ecliner and complained of his feet and hands urting. 10'n 3/10/22, at 1:13 p.m. the director of nursing DON) stated R10's care plan lacked dentification, goals, or interventions for edema, ain, pressure ulcers, and ADLs. The DON enrified nursing was responsible for completing and ensuring the residents care plan was omplete. 10's physician progress note dated 2/28/22, at 1:47 p.m. R10 was seated in his ecliner and stated he had pain in his hands. 10'n 3/8/22, at 1:47 p.m. R10 was seated in his ecliner and complained of his feet and hands urting. 10'n 3/10/22, at 1:13 p.m. the director of nursing DON) stated R10's care plan lacked dentification, goals, or interventions for edema, ain, pressure ulcers, and ADLs. The DON enrified nursing was responsible for completing and ensuring the residents care plan was omplete. 10's payrent dentification for the precision of the facility policy titled Care Plan - teviewes/Conferences revision date 5/2020, dicated the care plan review/conference would equarterly and as needed and would provide an redepth review of the resident's plan of care. 11's payrent dentification for the precision of the facility policy titled care Plan review/conference would equarterly and as needed and would provide an redep	A BUILDING 245138 A BUILDING A BUILDING B WING STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONAN STREET ELY, MN 55731 SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) FROM The Provider's PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDER'S PROPRIED AND ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDER'S PLAN OF CORRECTION FROM THE APPROPRIATE LY, MN 55731 PROVIDER'S PLAN OF CORRECTION FROM THE APPROPRIATE LY, MN 55731 PROVIDER'S PLAN OF CORRECTION FROM THE APPROPRIATE LY, MN 55731 PROVIDER'S PLAN OF CORRECTION FROM THE APPROPRIATE LY, MN 55731 PROVIDER'S PLAN OF CORRECTION FROM THE APPROPRIATE LY, MN 55731 PROVIDER'S PLAN OF CORRECTION FROM THE APPROPRIATE LY, MN 55731 PROVIDER'S PLAN OF CORRECTION FROM THE APPROPRIATE LY, MN 55731 PROVIDER'S PLAN OF CORRECTION FROM THE APPROPRIATE LY, MN 55731 PROVIDER'S PLAN OF CORRECTION FROM THE APPROPRIATE LY, M

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	FIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED		
		245138	B. WING			C 10/2022	
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP C 200 WEST CONAN STREET ELY, MN 55731	TE, ZIP CODE		
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F 657	be- (i) Developed within the comprehensive (ii) Prepared by an includes but is not (A) The attending p (B) A registered nu resident. (C) A nurse aide wi resident. (D) A member of for (E) To the extent properties of the resident and the An explanation must medical record if the and their resident root practicable for the resident's care plar (F) Other appropriate disciplines as deteror as requested by (iii)Reviewed and root team after each as comprehensive and assessments. This REQUIREMED by: Based on observative review, the facility for was revised to add 1 of 13 resident's (IF). Findings include:	mprehensive care plan must n 7 days after completion of assessment. interdisciplinary team, that limited to ohysician. rse with responsibility for the ith responsibility for the od and nutrition services staff. racticable, the participation of e resident's representative(s). st be included in a resident's ne participation of the resident epresentative is determined the development of the n. ate staff or professionals in rmined by the resident's needs the resident. evised by the interdisciplinary sessment, including both the d quarterly review NT is not met as evidenced tion, interview, and document failed to ensure a care plan ress significant weight loss for R16) reviewed for care plans. ecord printed 3/10/22, gnoses included Alzheimer's	F 6	Immediate Corrective Action The care plan for R13 was address the resident □s cur status. Corrective Action as it Appl An audit will be completed nutrition care plans are cur resident based on the residention individual needs. Other resident care plans we	updated to rent nutritional ies to Others: to ensure rent for each lent⊡s		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	COM	E SURVEY PLETED
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F 657	R16's annual Minim 1/27/22, indicated Fimpaired, required dependence on act and was dependen R16's MDS identified R16's Care Area As 1/27/22, triggered into have this care plantered was needed addition, the CAA to edentulous, does in have a trial of pured R16's care plan initial indicated R16 would as needed, general an evening snack. nutrition/hydration in would receive a regnutritional supplem willing to accept. The would need to be fellowed by the supplem willing to accept. The would need to be fellowed by the supplem willing to accept. The would need to be fellowed by the supplem without dentures by the supplementation of th	num Data Set (MDS) dated R16 was severely cognitively extensive assistance to ivities of daily living (ADLs) to no others to eat. In addition, ed weight loss. Seessment (CAA) dated nutritional status, and the need anned. The CAA indicated a difference of the first	F 65	as needed, based on the farensure nutrition care plans accurately and reflect the rourrent nutritional status. Prevent Recurrence: The policy and procedure for comprehensive care plans and remains current. Licensed nursing staff will the policy. Date Certain: April 8, 2022 Ongoing Monitoring: Weekly audits will be compresidents have nutrition care on the resident sindividual Audits will be completed as 5 times per week X 2 weeds 2 times per week X 2 weeds 2. Weekly X 4 weeks A Summary of audit results reviewed during the month meeting for the next 60 day recommendations. Monitored By: DON or designee	are completed esident s for was reviewed be educated on bleted to ensure re plans based al needs. It is follows: eks eks	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		TE SURVEY MPLETED C
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PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 657	A 2/17/22, 2:14 p.n had a slow continu R16 weighed 99.4 weight was 85.4 poindicated she was R16's physician ordindicated R16's ordsoft diet. In addition house supplement document the percono 3/9/22, at 7:07 in bed on her left s On 3/9/22, at 8:10 on the unit. On 3/9/22, at 8:22 her breakfast tray. On 3/9/22, at 9:19 sat at R16's bedsic was a mechanical On 3/9/22, at 9:31 R16 had eaten 60% On 3/9/22, at 12:18 the dining room at On 3/9/22, at 12:36 she ate approxima started spitting foor R16 eat at that poin On 3/10/22, at 8:35 she was fed by NA breakfast.	n. dietary note indicated R16 ous weight loss. On 7/12/21, pounds. On 2/14/21, R16's bunds. The dietary note tolerating a pureed diet. ders dated after 3/10/22, dered diet was a mechanical n, four ounces of Boost or three times a day and to ent taken. a.m. R16 was observed lying ide. a.m. the breakfast trays arrived a.m. R16's roommate received a.m. after staff performed or refused to get up out of bed. a.m. nursing assistant (NA)-A de and fed her breakfast, which soft as ordered. a.m. dietary aide (DA)-A stated of her breakfast. b p.m. R16 was seated alone in a table. c p.m R16 was fed by NA-A tely 50% of her meal and then dout. NA-A stopped helping int.	F 65	57		

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F 688	DON confirmed R ² with her current ph had her diet as ger were for a mechan no one had update most recent care of DON verified nursi ensuring care plan current. The facility policy to Reviews/Conferent indicated the care be quarterly and as in-depth review of Increase/Prevent E	d a continued weight loss. The 16's current care plan conflicted ysician orders. The care plan neral and the physician orders it also and the resident and kept are updated and kept are revision dated 5/2020, plan review/conference would a needed and would provide an the resident's plan of care. Decrease in ROM/Mobility	F 6			4/8/22
SS=D	§483.25(c) Mobility §483.25(c)(1) The resident who enter range of motion do range of motion un condition demonst of motion is unavous §483.25(c)(2) A remotion receives apprevent further deceives appropria assistance to main the maximum practice.	facility must ensure that a sthe facility without limited bes not experience reduction in aless the resident's clinical rates that a reduction in range				

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		245138	B. WING			10/2022
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 688	by: Based on observareview, the facility motion (ROM) served who had identified fingers and thumb decrease in ROM. Finding include: R20's annual Minity 7/26/21, indicated included Parkinsor diabetes. R20 requitotal assist with all and mobility. R20 hupper extremities a ROM of both lower R20's quarterly MER20 had diagnosed disease, demential cognitive impairment assistance with all R20's ROM was not either the upper or R20's quarterly Min 1/22/22, indicated included Parkinsor diabetes. R20 had and required extensactivities of daily like had impaired ROM extremities and am R20's activities of daily like had impaired ROM extremities and am R20's activities of dassessment (CAA)	ation, interview and document failed to provide range of vices for 1 of 3 residents (R20) ROM limitations in his left and had sustained a potential mum Data Set (MDS) dated R20 had diagnoses that his disease, dementia, and aired extensive assistance to areas of daily living (ADLs) had no ROM impairments to his extremities. 2S dated 10/22/21, indicated is that included Parkinson's and diabetes. R20 had severe areas of ADLs and mobility. Ot assessed for impairments on	F 688	Immediate Corrective Action: Resident R20 was reassessed, a orders were obtained for Occupa Therapy to evaluate and treat. Themploys a COTA and PTA and thindividuals will be utilized to condactivities with residents upon reference. Corrective Action as it Applies to An audit will be completed to ensidents who have or are at risk limited ROM or mobility are receinursing services to improve or prodecrease in ROM or mobility. Interventions will be implemented ensure any identified residents areceiving appropriate nursing serbased on the facility audit. Prevent Recurrence: The policy and procedure for resinursing services was reviewed aremains current. Licensed nursing staff will be edut the policy. Date Certain: April 8, 2022 Ongoing Monitoring: Weekly audits will be completed to residents with limited ROM or moreceiving nursing services prevendedline in functional status. Audit completed as follows: 5 times per week X 2 weeks 2 times per week X 2 weeks Weekly X 4 weeks	tional he facility ese uct ROM erral. Others: ure other for ving event a I to re vices corative and acated on to ensure obility are bit a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245138	B. WING			03/10/2022	
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F 688	people and use of the transfer and was not functional status was plan to avoid compidentification of any extremities. R20's Pain Assessi 1/21/22, indicated FR20's Occupational Summary dated 8/2 being discharged from ain residing in the excellent to maintal with consistent staff recommendations of the upper expensiving. Review of Ormodoty of the upper expensive of the u	he mechanical stand lift to on-ambulatory. R20's as to be addressed in the care lications. The CAA lacked or contractures with R20's ment Screening Tool dated R20 did not complain of pain. I Therapy (OT) Discharge R8/20, indicated R20 was om OT services, but would he facility. His prognosis was in his current level of function of support. Discharge were to continue daily teral upper extremity ROM for support of functional stremities in activities of daily T notes from start of services ge from services 8/28/20, or of any contractures or R20's left hand. Tapy (PT) Discharge Summary cated R20 was able to the with moderate assistance in 20's prognosis to maintain his ection was good with consistent. Discharge recommendations of the bed for core of PT notes from initiation of or discharge from services ontification of any contractures on the part of the part o	F 6	888	A Summary of audit results will be reviewed during the monthly QAPI meeting for the next 60 days for fu recommendations. Monitored By: DON/Designee		

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F 688	had Parkinson's disencourage exercisperform ADLs and decline to the phys symptoms of Parki included poor balar cramps or rigidity, plan identified R20 related to his Parki Staff were directed signs and symptom forming or worseni care plan lacked id contracture, as we guard to this left had R20's progress not were reviewed, wh R20's contracted (muscles, tendons, causes the joints to stiff. This prevents other body part) le 2/18/22, was the fir symptoms of pain a contracture. This p R20 began to resish left hand. Ther progress notes, or sheets regarding ir guard. A progress note dawas seen by a phy contracture and a resistant progress note and a resistant progress note dawas seen by a phy contracture and a resistant progress note and a resistant progress note dawas seen by a phy contracture and a resistant progress note dawas seen by a phy contracture and a resistant progress note and progress note a	A progress note dated 2/22/22, indicated R20 was seen by a physician for his left hand pain and contracture and a referral for a surgery consult was received. Although R2 was palm guard,		688			

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NAME OF PROVIDER OR SUPPLIER BOUNDARY WATERS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COL 200 WEST CONAN STREET ELY, MN 55731				
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F 688	Physician clinic vis R20 was first seen with complaints of he was going to minjection for this type that set up. The place of the place	it note dated 2/22/22, indicated for contracture to his left hand pain. The physician indicated ake a surgical referral for oe of issue and he would get hysician indicated amputation	F 68	8				
	sitting in the dining a soft palm guard punable to turn his his fingers of his left honoracted and stiff and was worse who buring interview or assistant (NA)-A stontracted but it has would become mo move or even touch the palm guard. Nitell it bothered R20	o a.m. R20 was observed room eating breakfast. He had blaced in his left hand. He was hand to face upward and the and appeared tightly f. R20 stated his left hand hurt en touched. on 3/9/22, at 2:51 p.m. nursing stated R20's left hand had been ad recently gotten worse. R20 are agitated when they tried to h his left hand and he resisted A-A indicated you could really more than it had before. NA-A not do ROM exercises with						

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		245138	B. WING				10/2022
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F 688	(DON) and the assi (ADON) on 3/9/22, the facility staff did They did not have a residents and they therapy regarding Fassessments for the as she had been to them to be completed not been done on Fand the ADON was assessment had be DON stated R20's was not identified oppoblem with intervidentified. During interview on occupational therapassisted residents with the therapist had consequently the program. 7/30/20, through 8/2 admitted to the facilibut she was never contracture and OT palm guard for his limust have implement was not aware R20 his hands. If R20 with she would have the involved OT. OTAmassage, warm so may have helped a avoided a surgical of the state of the surgical of the state of the surgical of	w with the director of nursing istant director of nursing at 1:26 p.m. the ADON stated not do ROM with residents. A ROM program for any of their should be talking more with ROM exercise. The ROM e MDS's were not being done ying to figure out a way for red. A ROM assessment had R20 since before July 2021, unsure when the last ROM een completed for R20. The contracture to his left hand on his care plan and the entions should have been and She had worked with R20 (OTA)-A indicated she with their OT exercises after ompleted the screening and She had worked with R20 (28/20, when he was first lity. His hand was a little tight, made aware R20 had a had not implemented the hand. OTA-A stated nursing ented the palm guard as she was having any issues with as having pain in his hand, ought nursing would have A indicated sometimes gentle aks and other interventions and could have possibly	F6	88			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONAN STREET ELY, MN 55731	03/10/2022
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F 688	attempting to open R20 immediately be grimace. R20 was arm in full extension hand to face palm of fingers on his left has unable to get to the skin of his left pwould have had to left hand in order to documented in R20 2020 through Augubeen able to grasphis left hand was to his hand had starte weeks.	R20's fingers to his left hand. egan to complain of pain and unable to straighten his left in and was unable to rotate left up. OTA-A indicated R20's and were very tight and she hem open enough to assess palm. OTA-A indicated he have more movement in his o use the parallel bars as was 0's therapy notes from July st 2020. R20 would not have the parallel bars currently as a contracted now. R20 stated and hurting him more in recent	F 68	8	
	2020, indicated all maintain or attain the functioning. All research admission and at expossible inclusion in Restorative programmanagement, ROM training and skill profit facility policy R dated May 2020, in provide physical, or	tehabilitation Service Orders dicated the facility would ccupational and speech			
	therapy to attain or prevent decline with treatment plan. Nutrition/Hydration CFR(s): 483.25(g)(maintain function and/or n a physician ordered Status Maintenance	F 69	2	4/8/22

	PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING CON		E SURVEY PLETED			
		245138	B. WING _			C 10/2022
	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP O 200 WEST CONAN STREET ELY, MN 55731		10/2022
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F 692	both percutaneous percutaneous endocenteral fluids). Bas comprehensive assensure that a residual \$483.25(g)(1) Main of nutritional status desirable body weigh balance, unless that preferences indicated \$483.25(g)(2) Is off maintain proper hydroxider orders a that the provider orders and the provider orders are provider orders and the provider orders are provider orders.	tric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and ed on a resident's ressment, the facility must ent- tains acceptable parameters, such as usual body weight or ght range and electrolyte resident's clinical condition this is not possible or resident e otherwise; rered sufficient fluid intake to dration and health; rered a therapeutic diet when I problem and the health care	F 69	,		
	prevent continued of (R17) reviewed for weight loss of 18 per Findings include: R17's significant ch (MDS) 1/28/22, ide including atrial fibril	o interventions to reduce or weight loss for 1 of 2 residents nutrition and sustained a bunds in a two month period. ange Minimum Data Set ntified R17 had diagnoses lation (irregular heart beat),		loss and interventions were to reduce or prevent contin loss. An order for a nutrition was obtained, the culinary with R17 daily to determine dislikes and intakes are not Corrective Action as it Appl An audit of residents who had noted weight loss without contangent and prevent and to residents and interventions to prevent and to reduce the prevent and the prevent	ued weight hal supplement director meets food likes and w monitored. ies to Others: lave had a urrent	
	(the lower portion of due to acid reflux d clostridium difficile.	ey disease, Barretts esophagus f the colon thick and inflamed isease), and entercolitis due to R17 had intact cognition and n with eating. R17's height		interventions to prevent or continued weight loss will be interventions to reduce or ploss will be implemented by findings.	e completed. prevent weight	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМІ	E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	recorded at 160 por a weight gain or los R17's Physician Ore R17 was to receive soft texture diet. R17's Care Plan with nutritional or dietary were documented. R17's Nutritional Cadated 2/8/22, indicaroom and was a "pi experiencing some requested small me problems chewing reconsumption was to weights weekly. And dietician was indicaded in the state of	inches and her weight was unds. The MDS did not identify is had occurred. ders dated 3/10/22, indicated a no added salt, mechanical the print date 3/10/22, lacked a refocus and no interventions. Are Area Assessment (CAA) ated R17 ate her meals in her ocky eater". She had been nausea and pain and eals. She identified having meat at times. Meal to be monitored daily and referral to a registered ated for a full assessment. Ary progress note indicated existence. Her initial weight of a 1/4/22, was down "a bit" to eight was recommended to reight loss. R17's intake at the progress note indicated R17 and weight loss and her weight was recommended to reight loss and her weight as supplements two times are to encourage meal intakes and add R17 to her monthly	F 6	i92	Prevent Recurrence: The policy and procedure for weight was reviewed and remains current Licensed nursing staff will be educt the policy. Date Certain: April 8, 2022 Ongoing Monitoring: Weekly audits will be completed to appropriate interventions are implet to reduce or prevent weight loss bathe resident individual needs. A will be completed as follows: - 5 times per week X 2 weeks - 2 times per week X 2 weeks - Weekly X 4 weeks A Summary of audit results will be reviewed during the monthly QAPI meeting for the next 60 days for furecommendations. Monitored By: DON or designee	ensure emented ased on audits	
	reviews. R17's Search Vitals	Results listing dated from					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE (A. BUILDING			(X3) DATE SURVEY COMPLETED C	
	245138	B. WING _		03/10/2022
			STREET ADDRESS, CITY, STATE, ZIP O 200 WEST CONAN STREET ELY, MN 55731	
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	N SHOULD BE COMPLÉTION
owing recorded in 1/4/22, R17 vin 1/7/22, R17 vin 2/17/22, R17 vin 3/7/22, R17	weights for R17: weighed 162 lbs; weighed 159 lbs; weighed 141 lbs, and weighed 144 lbs. (an 18 lb. days). ord was reviewed and lacked had been comprehensively aluated for this loss of weight, evidence any new interventions ned or implemented to help e continued loss of weight. The ce a day supplements had not d as recommended by the on 3/10/22, at 9:36 a.m. (NA)-B stated R17 frequently hach, so she sometimes did not ticed a weight loss, they would owever, they were unable to nt's weight to the previous hights. They just turned in the e resident's current weight and onter and track the weights. ew with licensed practical nurse C on 3/10/22, at 9:43 am.		,	
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR Intinued From prowing recorded In 1/4/22, R17 with a 1/7/22, R1	DENTIFICATION NUMBER: 245138 DEER OR SUPPLIER WATERS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 31 Dowing recorded weights for R17: In 1/4/22, R17 weighed 162 lbs; In 1/7/22, R17 weighed 159 lbs; In 2/17/22, R17 weighed 141 lbs, and In 3/7/22, R17 weighed 144 lbs. (an 18 lb. light loss in 60 days). The medical record was reviewed and lacked of evidence R17 had been comprehensively seessed or evaluated for this loss of weight, at there was no evidence any new interventions are being screened or implemented to help event or slow the continued loss of weight. The commended twice a day supplements had not an implemented as recommended by the tician. The interviewed on 3/10/22, at 9:36 a.m. sing assistant (NA)-B stated R17 frequently an upset stomach, so she sometimes did not well. If they noticed a weight loss, they would iffy the nurse, however, they were unable to impare a resident's weight to the previous ght or track weights. They just turned in the hisheet with the resident's current weight and nurse would enter and track the weights. This implemented with licensed practical nurse and LPN-C on 3/10/22, at 9:43 am. N-A stated the nurses entered the weekly bath	DENTIFICATION NUMBER: 245138 B. WING WATERS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 31 Powing recorded weights for R17: In 1/4/22, R17 weighed 162 lbs; In 2/17/22, R17 weighed 159 lbs; In 2/17/22, R17 weighed 141 lbs, and In 3/7/22, R17 weighed 144 lbs. (an 18 lb. Inght loss in 60 days). T's medical record was reviewed and lacked of evidence R17 had been comprehensively seessed or evaluated for this loss of weight, at there was no evidence any new interventions re being screened or implemented to help event or slow the continued loss of weight. The commended twice a day supplements had not en implemented as recommended by the tician. Interviewed on 3/10/22, at 9:36 a.m. Ising assistant (NA)-B stated R17 frequently an upset stomach, so she sometimes did not well. If they noticed a weight loss, they would iffy the nurse, however, they were unable to mpare a resident's weight to the previous ght or track weights. They just turned in the habeet with the resident's current weight and nurse would enter and track the weights. Ting joint interview with licensed practical nurse in the habeet with the resident's current weight and nurse would enter and track the weekly bath	IDENTIFICATION NUMBER: 245138 245138 B. WING STREET ADDRESS, CITY, STATE, ZIP OF CONTROL OF CON

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED C
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONAN STREET ELY, MN 55731		
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F 692	inform nursing of the Nursing would get supplements on the record (MAR). LP aware R17 had a verbally notified the loss in weight, do any needed followhen interviewed DM-A stated the dould always contained been visiting with the trays that she knew complaints of naus going to have an expounds back last withings were improved more commended supplemented by the day dietary supplements and it should daily interdisciplinate would typically revolves at IDT meeting supplements should be added, I done regarding R1 supplements should by physician should the recommended to the rec	it would not flag. DM-A would he need for supplements. an order and schedule the see medication administration N-C indicated she was made weight loss and she had e director of nursing (DON) of She had left it with the DON to low up on it. on 3/10/22, at 10:01 a.m. ietician came monthly, but they act her by phone if needed. of R17's weight loss and had her and adding extra food to her w R17 liked. R17 had made sea and feeling like she was emesis. R17 had gained two week and DM-A was confident ving. When the dietician oplements, nursing was taining the order and setting as not sure if she had informed a recommendation for twice a	F 69.	2		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION (C C COMPLETED
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F 710	The facility policy W May 2020, indicated residents who enter below their ideal boviewed as unavoidarisk for weight loss plan with individualiconsults would be complemented. Dietanotes would address Resident's Care Su CFR(s): 483.30(a)(A and notify the physician. Veight Loss with review date of the facility would ensure red the facility would not fall dy weight range, unless it was able. Residents identified as at would be noted on their care zed interventions. Dietary completed and suggestions ary or designee and nurse's as weight loss issues. pervised by a Physician 1)(2) Services	F 69		4/8/22
	recommendation the a facility. Each resistant, nurse prospecialist must provimmediate care and §483.30(a) Physician The facility must ensure supervised by a possible super	an Supervision. sure that- medical care of each resident ohysician; ner physician supervises the idents when their attending		Immediate Corrective Action: A physician □s order was obtained for to receive nutritional supplements.	or R17

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NAME OF I	PROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE,		
				200 WEST CONAN STREET		
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F 710	Continued From p	age 34	F 7	10		
	twice a day supple failed to obtain phy 2 resident (R282) therapy five times receiving therapy simple Findings include: R17's significant of	loss and recommendations for ements. In addition, the facility ysician orders/guidance for 1 of who had orders for physical weekly and who would not be services as ordered.		The physician □s was up resident R282 did not resident R282 did not resident R282 therapy as ordered. Corrective Action as it A An audit will be completed residents with dietary residents orders to resident or nutritional supplements orders to resident or nutritional supplements orders to resident or nutritional supplements orders to resident orders t	eceive therapy as 2 is now receiving applies to Others: ted to ensure others are to have eceive	er
	(MDS) 1/28/22, ide including atrial fibr hypertension, kidn (the lower portion due to acid reflux clostridium difficile required supervision was recorded as 6 recorded at 160 pc R17's Physician O	entified R17 had diagnoses rillation (irregular heart beat), ley disease, Barretts esophagus of the colon thick and inflamed disease), and entercolitis due to a. R17 had intact cognition and on with eating. R17's height 64 inches and her weight was		supplements per dietary recommendations. An audit will be complet residents with physical thave orders in accordar recommendations. Prevent Recurrence: The policy and procedu Physician/Family Notific reviewed and remains of Licensed nursing staff withe policy.	ted to ensure other therapy orders nce with therapy re for cation was current.	
	nutritional or dieta were documented R17's Nutritional C dated 2/8/22, indic room and was a "p experiencing some requested small m problems chewing consumption was weights weekly. A dietician was indic	with print date 3/10/22, lacked a ry focus and no interventions. Care Area Assessment (CAA) cated R17 ate her meals in her bicky eater". She had been e nausea and pain and neals. She identified having meat at times. Meal to be monitored daily and a referral to a registered cated for a full assessment.		Ongoing Monitoring: Weekly audits will be codietary and therapy recommunicated to the phwill be completed as follows: 5 times per week X 2 volumes are week X 2 volumes. A Summary of audit reserviewed during the momeeting for the next 60 recommendations.	ompleted to ensur ommendations are nysician. Audits lows: weeks weeks weeks ults will be nthly QAPI	

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F 710	163 pounds (lbs) or lbs. Another weight no further weight lo 50-100 percent. On 2/17/22, a dieta continued to have a was now down to 1 recommended as weight per day. Staff were and the dietician were reviews. R17's Search Vitals admission 1/4/22, to following recorded weight loss in 1/4/22, R17 weight loss in 60 day and there was no ewere being screened and there was no ewere being screened prevent or slow the recommended twice been implemented dietician. During interview on	eviewed. Her initial weight of a 1/4/22, was down a bit to 159 to was recommended to ensure ss. R17's intake at meals was ry progress note indicated R17 a weight loss and her weight 31 lbs. Another weight was well as supplements two times to encourage meal intakes ould add R17 to her monthly a Results listing dated from a 3/7/22, identified the weights for R17: eighed 162 lbs. eighed 159 lbs, veighed 141 lbs, and	F 7	710	Monitored By: DON or designee		

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F 710	aware R17 had a w verbally notified the the loss in weight. do any needed follow When interviewed on DM-A stated when supplements, nursi obtaining the order was not sure if she the recommendation supplements. During interview on DON stated he had loss and it should had ally interdisciplinate would typically reviel loss at IDT meeting should be added, he done regarding R1 supplements should recommended by the physician should have resident's weight lo notified him of a resident's with DM-ATHE facility policy Windy 2020, indicated residents who enteresidents would be of implemented. Diet	veight loss and she had director of nursing (DON) of She had left it with the DON to	F 7′			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION) COM	TE SURVEY MPLETED
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F 710		ige 37 Imentation in the medical	F 7	'10			
	R282 was admitted diagnoses including	mission Record identified I to the facility 2/24/22, with g fracture of the right lower leg, nyeloma, anxiety, weakness, muscle spasms.					
	3/10/22, indicated F	er Summary Report dated Physical Therapy (PT) and apy (OT) were to evaluate and					
	Assessment (CAA) required assistance due to a recent righ non weight bearing risk for falls. PT an	Daily Living (ADLs) Care Area dated 3/4/22, identified R282 with his ADLs and mobility at ankle fracture and he was to his right leg. R282 was at ad OT services were ordered etraining and safety					
	2/25/22, identified F therapeutic exercis reeducation, gait tra	on and Treatment Plan dated R282 would be seen for es, neuromuscular aining therapy, and therapeutic per week for thirty days.					
	3/9/22, were review were provided 2/25 3/3/22 and 3/7/22.	es from 2/25/22, through yed and identified PT services /22, 2/28/22, 3/1/22, 3/2/22, No therapy visit had been 2, 3/8/22, and 3/9/22.					
		on 3/7/22, at 3:46 p.m. R282 eceiving therapy as often as					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY IPLETED	
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F 710	was ordered and he time. During interview on occupational therap facility usually has p through Friday but t (PTA)-A was off for physical therapist w two times per week	ge 38 e was in his bed most of the 3/10/22, at 8:29 a.m. by aide (OTA)-A stated the chysical therapy daily Monday the physical therapy aide two weeks. OTA-A stated the rould be coming to the facility and would do PTA-A s with the residents on those	F 7	10		
	director of nursing (not making visits wi would need to notify missed visits and o aware the PTA-A w	3/10/22, at 2:54 p.m. the (DON) stated if therapy was ith a resident as ordered they y the primary physician of the btain new orders. He was as not working for 2 weeks 2 R282's physician of the				
	Change in Residen date November 201 notify the physician alter treatment sign	Resident Representative of t Health Status with revision 16, indicated the facility would whenever there was a need to ificantly. ecialized Rehab Services	F 8.	25		4/8/22
	§483.65(a) Provision of If specialized rehability not limited to physic pathology, occupating therapy, and rehability.	d rehabilitative services. on of services. ilitative services such as but cal therapy, speech-language conal therapy, respiratory litative services for mental ual disability or services of a				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG	СОМ	E SURVEY PLETED
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F 825	required in the rescare, the facility m §483.65(a)(1) Prov §483.65(a)(2) In a obtain the required resource that is a rehabilitative serviparticipating in any programs pursuanthe Act. This REQUIREMED by: Based on observative, the facility therapy as ordered reviewed for thera. Findings include: R282's undated Act R282 was admitted diagnoses includir diabetes, multiple abnormal gait and R282's Active Ord 3/10/22, indicated Occupational There treat as ordered. R282's admission dated 2/28/22, indicognition and did a symptoms. The M	set forth at §483.120(c), are ident's comprehensive plan of ust- vide the required services; or ccordance with §483.70(g), diservices from an outside provider of specialized ces and is not excluded from y federal or state health care at to section 1128 and 1156 of entered at the sectio	F 82	Immediate Corrective Action The physician was updated R282 did not receive therapy Resident R282 is now receivi as ordered. Corrective Action as it Applies An audit will be completed to residents with physician s or physical therapy are receiving accordance with the prescribe physician s order. Prevent Recurrence: The policy and procedure for Services was reviewed and recurrent. Licensed nursing staff will be the policy. Date Certain: April 8, 2022 Ongoing Monitoring: Weekly audits will be comple	that resident as ordered. ng therapy sto Others: ensure other ders for g services in ed Restorative emains educated on	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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BOUNDA	PROVIDER OR SUPPLIER ARY WATERS CARE O	CENTER ATEMENT OF DEFICIENCIES	STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONAN STREET ELY, MN 55731			ECTION (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)) BE	COMPLETION DATE
F 825	R282's ADL Care A 3/4/22, identified R: his ADLs and mobil fracture and he was right leg. R282 was ervices were orderetraining and safet R282's PT Evaluati 2/25/22, identified F therapeutic exercis reeducation, gait tractivities 5 times per R282's PT visit not 3/9/22, were review were provided 2/25 3/3/22 and 3/7/22. I completed on 3/4/2 When interviewed on stated he was not rewas ordered and he time. During interview on occupational theraperical therapist was times per week a exercises with the report of nursing interview on director of nursing intervie	area Assessment (CAA) dated 282 required assistance with lity due to a recent right ankle is non weight bearing to his as at risk for falls. PT and OT red for strengthening, ty awareness.	F8	225	therapy services are provided as prescribed by the resident sphys Audits will be completed as follows - 5 times per week X 2 weeks - 2 times per week X 2 weeks - Weekly X 4 weeks A Summary of audit results will be reviewed during the monthly QAPI meeting for the next 60 days for furecommendations. Monitored By: DON or designee	S:	

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F 886 SS=L	aware the PTA-A was she was on vaca R282's physician of The facility policy R with revision date N would provide physician or prevent decline with treatment plan. The physician orders for specific discipline, the COVID-19 Testing-CFR(s): 483.80 (h) COVID must test residents individuals providing and volunteers, for for all residents and individuals providing and volunteers, the §483.80 (h)((1) Corparameters set fort but not limited to: (i) Testing frequence (ii) The identification this paragraph diage COVID-19 in the facilii) The identification this paragraph with consistent with COVID suspected exposur (iv) The criteria for	btain new orders. He was as not working for two weeks at ion and he would notify if the missed visits now. estorative Services Orders May 2020, indicated the facility ical, occupational or speech maintain function and/or in a physician ordered e facility would obtain in rehabilitation services with creatment and duration. Residents & Staff (1)-(6) -19 Testing. The LTC facility and facility staff, including g services under arrangement COVID-19. At a minimum, if facility staff, including g services under arrangement LTC facility must: Induct testing based on the by the Secretary, including y; in of any individual specified in nosed with cility; on of any individual specified in symptoms VID-19 or with known or	F 8				4/8/22

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 886	COVID-19 in a council (v) The response (vi) Other factors is help identify and put transmission of Council (vi) S483.80 (h)((2) Council (vi) Document that results of each state (ii) Document in the was offered, compute to the resident's the each test. §483.80 (h)((4) Upindividual specified symptoms consistent with Council (vi) Document with Council (vii) Document in the was offered, compute to the resident's the each test. §483.80 (h)((4) Upindividual specified symptoms consistent with Council (vii) Document in the was offered, compute the symptoms consistent with Council (viii) Document in the was offered, compute the resident's testing or a system of Council (viii) Document in the was offered, compute the resident's testing or a system of Council (viii) Document in the was offered to be resident in the council (viii) Document in the was offered to be resident in the council (viii) Document in the was offered to be resident in the council (viii) Document in the was offered to be resident in the council (viii) Document in the was offered to be resident in the council (viii) Document in the was offered, compute the resident in the was offered to be resident in the council (viii) Document in the was offered, compute the resident in the council (viii) Document in the was offered, compute the viii) Document in	s the positivity rate of unty; time for test results; and specified by the Secretary that revent the DVID-19. Induct testing in a manner that current standards of practice for D-19 tests; or each instance of testing: testing was completed and the off test; and he resident records that testing pleted (as appropriate esting status), and the results of poon the identification of an and in this paragraph with DVID-19, or who tests positive the actions to prevent the DVID-19. Ave procedures for addressing for including individuals providing angement and volunteers, who are unable to be tested. The procedures in testing supplies or testing s	F8	386				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
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F 886	Based on interview facility failed to ens COVID-19 and had not allowed to work confirmatory real-tip polymerase chain raccording to CDC opractice resulted in situation which had serious illness and/residing in the facili. The IJ began on 1/nurse (LPN)-A repowas allowed to wor conducted antigen testing to follow up, guidance. On 1/18/positive with an antidirector of nursing/infection notified of the IJ on immediate jeopardy 12:29 p.m. when the interventions to ensaccording to CDC on compliance remseverity level of F, no actual harm with minimal harm that we Findings include: The CDC guidance Conditions dated 5/were more likely to COVID-19. More the	v and document review, the ure staff who had symptoms of negative antigen test(s) were	F	386	Immediate Corrective Action: Covid-19 testing was immediately implemented in accordance with CI recommendations including confirm testing for asymptomatic antigen poresidents and staff and staff performonfirmatory testing on symptomatic antigen negative residents and staff. Corrective Action as it Applies to Other An audit was conducted to identify oresidents and staff with symptoms of COVID-19 infection. Identified staff immediately removed from work an RT-PCR testing was performed in accordance with CMS guidance and recommendations. Prevent Recurrence: The policy and procedure for COVID-19 infection of Residents and Staff was reviewed and revised to conform to current standards of practice for testing of Residents and Staff for COVID-19. All staff were educated on the policinary revisions on 3/8/2022. Ongoing Monitoring: Weekly audits will be completed to continued compliance with CDC and recommendations for COVID-19 testion residents and staff. Audits will be completed as follows: 5 times per week X 2 weeks 2 times per week X 2 weeks Weekly X 4 weeks A Summary of audit results will be	natory positive ming c f. hers: other of were d CDC D-19 sting y	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 886	deaths have occur Further, among ad from COVID-19 ind adults at highest rist the person with CO hospitalization, interest help them breathe, STAFF TESTING: The Centers for Di (CDC) guidance Solution Term Care Fasymptomatic people should have a conformatory test is nucleic acid amplifulation reverse transcriptate (RT-PCR). As the generally lower that antigen tests should Testing of symptom personnel (HCP). If an antigen test in perform NAAT immensymptomatic residurans mission-base results return. If a confirmatory Nays, people should until the confirmator of instance, in gettests presumptive in NAAT is performed Transmission-Base result is available. The facility's Employer.	red in people older than 45. ults, the risk for severe illness creases with age, with older sk. Severe illness means that DVID-19 may require ensive care, or a ventilator to or they may even die. sease Control and Prevention ARS CoV-2 Antigen Testing in acilities dated 1/7/21, identified le who test antigen negative firmatory test performed. Should be performed with ications tests (NAAT) such as use polymerase chain reaction sensitivity of antigen tests is in RT-PCR, negative POC ld be considered presumptive. In the considered presumptive in the considered presumptive in the considered presumptive in the considered within 2 ld be assumed to be infectious orly test results are completed. In the considered presumptive in the complete stand and the considered should remain in the design of the considered presumptive in the complete stand and the considered should remain in the design of the considered presumptive in the complete stand and the considered should remain in the design of the considered presumptive in the complete stand and the considered presumptions until the NAAT of the considered presumptions un	F8	886	meeting for the next 60 days for fur recommendations. Monitored By: DON or designee	ther	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C			
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONAN STREET ELY, MN 55731	DE		
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F 886	reported symptom aches on 1/10/22. indicated LPN-A re COVID-19 each dausing an antigen to facility failed to test test. LPN-A tested facility antigen test was to work. LPN schedule. No community and the facility's updated January 3, 2022, the facility and 1/17/2 from the schedule positive for COVID test prior to starting from the schedule quarantine. No condone. During interview or facility infection procounty COVID-19. The facility tested testing and if it was allowed to work the tested because of evaluated them on the antigen test was to work their shift. symptoms with a required to wear a however, employe tested for N95 mas IP verified LPN-A recough and nasal county and the same an	age 45 s of cough, myalgia, and body The employee tracking tool epeatedly tested negative for ay of the four days she worked est for COVID-19. However, the t with a confirmatory RT-PCR d positive for COVID-19 with a t on 1/18/22, the fifth day she A was then removed from the firmatory RT-PCR was done. Ited employee schedule for through January 30, 2022, orked 1/10/22, 1/11/22, 22, and before being removed on 1/18/22, when she tested 0-19 with the facility's antigen g her shift. LPN-A was removed for a period of 10 day infirmatory RT-PCR test was In 3/7/22, at 4:34 p.m. the eventionist (IP) stated the transmission rate was high. Their employees with antigen is negative, the employees were eir shift. When an employee symptoms, the facility is a case by case basis and if as negative, they were allowed Employees with COVID-19 inegative antigen tests were in N95 mask while working, es, included LPN-A, were not fit is sks until February 2022. The inad worked with symptoms of ongestion for four days before with an antigen test on	F 88	6			

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
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F 886	1/18/22. The IP si facility was not usi testing, but did ind quick and easy. Temployees to the needed. If employ as a runny nose of tested negative wirequired them to wavere allowed to was end the employee confirmatory PCR positive and had savere sent home. If always used the astarted in August 2. When interviewed administrator state employees and reconly. The facility did encourage the test when/if they was COVID-19. When of illness, the facility antigen test and if appeared mild, the work. If symptoms send the employee perform confirmation negative antigen to reporting symptom. In an interview on stated they had out 1/8/22. Review of	tated she was not sure why the ng RT-PCR tests for their licate the antigen tests were hey were able to send clinic for a PCR test if it was wee symptoms were mild such recough and the employee than antigen test, the facility wear an N95 mask and they wear an N95 mask and they wear an N95 mask and they ork. The IP stated she did not est to the clinic for a test. If an employee tested ymptoms of COVID-19 they The IP stated the facility had ntigen tests long before she 2021. on 3/8/22, at 8:46 a.m. the ed the facility tested their sidents with antigen testing id not confirm negative or RT-PCR tests, however, they ir staff to obtain an RT-PCR vere symptomatic for employees reported symptoms ity would test them with an negative and symptoms ey would allow the employee to swere more severe, they would en home. The facility did not ory RT-PCR tests to confirm a est, even if the employee was	F 886				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
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F 886	on 1/8/22. This war reported her COVII to work. No resider at the time LPN-A had symptoms in J tested for COVID-1 [negative antigen to tested positive for COVID-19 [negative antigen to tested positive for COVID-19 February 4, 2022, i or signs of COVID-status, would be te expected to be resithe results of COVID-19 should freturn to work. The what test the facility and residents. The IJ which begar 3/9/22, at 12:29 p.r. through interview a immediately impler accordance with Confirmatory testing positive residents facility would follow prevention and con and staff with symp. The facility reviewer reflect protocols for and residents were manner consistent.	age 47 as only 2 days before LPN-A D-19 symptoms and continued ats were positive for COVID-19 and symptoms. Two residents anuary (onset 1/10/22 [not 9], and onset 1/24/22 est]). Three other residents COVID-19 on 2/5/22. Infection Prevention and Testing, with revision date andicated staff with symptoms 19, regardless of vaccination sted immediately and were tricted from the facility pending ID-19 testing. If COVID-19 and, staff who had symptoms of follow the facility policy for the policy lacked identification of any was to use for testing of staff and on 1/10/22, was removed on any, when it could be verified and document review the facility and document review the facility and document review the facility and staff and performing and staff and performing and staff. In addition, the arecommended infection are of the area and a traff.	F 8	86		

NAME OF PROVIDER OR SUPPLIER BOUNDARY WATERS CARE CENTER CAN UP DEFICIENCY MUST BE PRECEDED BY FILL TAG	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l	TIPLE CONSTRUCTION ING	COM	(X3) DATE SURVEY COMPLETED	
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F 886 Continued From page 48 provided to all employees on current and updated PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTIO DATE) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 886 PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			I		STREET ADDRESS, CITY, STATE, ZIP C 200 WEST CONAN STREET		10/2022
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 22, 2022

Administrator Boundary Waters Care Center 200 West Conan Street Ely, MN 55731

Re: State Nursing Home Licensing Orders

Event ID: 07UP11

Dear Administrator:

The above facility was surveyed on March 7, 2022 through March 10, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Boundary Waters Care Center March 22, 2022 Page 2

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susan Frericks, Unit Supervisor Metro D District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health PO Box 64990 St. Paul MN 55164-0900

Email: susan.frericks@state.mn.us

Mobile: (218) 368-4467

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

PRINTED: 05/17/2022 FORM APPROVED

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ С

		00587		B. WING			03/1	0/2022
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	****ATTE	NTION*****						
	NH LICENSING	CORRECTION ORDE	:R					
	144A.10, this correct pursuant to a surver found that the deficit herein are not corrected shall I with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Rull When a rule contain comply with any of the lack of compliance. re-inspection with a result in the assess	nether a violation has t	ssued n, it is ited iolation lance ule of peen ag elow. e to dered upon ule will the item					
	that may result from orders provided tha the Department with	hearing on any assess n non-compliance with t a written request is n nin 15 days of receipt on nt for non-compliance	these nade to of a					
	was conducted at y the Minnesota Depa facility was found N State Licensure and orders are issued. F	S: 3/10/22, a licensing successive surfacility by surveyor artment of Health (MD) OT in compliance with the following corrective see indicate in your prrection you have review.	rs from H). Your the MN on					

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

Electronically Signed 03/31/22

STATE FORM 6899 07UP11 If continuation sheet 1 of 26

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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	these orders and id be completed.	lentify the da	te when they will				
	The following comp UNSUBSTANTIATI MN65547, MN6554	ED: H513804					
	Minnesota Departmenthe State Licensing federal software. To assigned to Minnes Nursing Homes. The appears in the far leading to the state state of the correction order the findings which a statute after the state as evidence by." For are the Suggested Time period for Correction for Correction for Correction for Corrections.	Correction of ag numbers lead a state state state assigned the assigned of the assigned of the arrows are in violaticate of the arrows are in violaticate of the assigned of the assigned of the assigned of the arrows are in violaticate of the assigned of the assigned of the arrows are in violaticate of the arrows are in violaticate of the assigned of the arrows are in violaticate.	Orders using have been stutes/rules for tag number intitled "ID Prefix of compliance is ent of Deficiencies" omply" portion of an also includes on of the state is Rule is not met surveyors findings orrection and				
	You have agreed to receipt of State lice the Minnesota Dep Informational Bullet https://www.health.n/infobulletins/ib14 orders are delineate Department of Hea you electronically. is necessary for State enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Department of State Incensure procompletion date, the corrected prior to e Minnesota Department of State Incensure procompletion date, the corrected prior to e Minnesota Department of State Incensure procompletion date, the corrected prior to e Minnesota Department of State Incensure processing the state In	ensure orders artment of H tin state.mn.us/ _1.html The ed on the att lth orders be Although no ate Statutes/rected" in the indicate in to cess, under the date your olectronically	s consistent with ealth facilities/regulatio State licensing ached Minnesota sing submitted to plan of correction Rules, please box available for he electronic the heading orders will be submitting to the				

Minnesota Department of Health

STATE FORM 6899 07UP11 If continuation sheet 2 of 26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED		
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2 303	MN Rule 4658.0405 Plan of Care; Use Subp. 3. Use. A comust be used by all care of the resident	omprehensive plar personnel involve	of care	2 565			4/8/22
	This MN Requirements: Based on observation review, the facility for centered comprehers and included interversident symptoms potential for declinerand/or treatment for shortening of a must residents (R20, R10 care plans. Findings include:	on, interview and on ailed to ensure a property plan of care the entions to assess a related to their diated, addressed care for contractures (a poscle or joint) for 2 of ailed and a poscle or joint) for 2 of ailed and ailed ailed and ailed and ailed ailed and ailed ailed ailed ailed and ailed ail	document erson identified and treat ignoses, needs ermanent of 13		Corrected.		
	R20's undated Adm had diagnoses of P and diabetes.						
	R20's quarterly Min	imum Data Set (M	DS) dated				

6899

Minnesota Department of Health STATE FORM

PRINTED: 05/17/2022 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF AND PLAN OF CORRECTION IDENTIFICATION NUM	IDED:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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1/22/22, indicated R20 had severe cognit impairment and required extensive assis with all activities of daily living (ADLs). R impaired range of motion (ROM) on one his upper extremities and did not ambula R20's ADL Care Area Assessment (CAA) 7/21/21, indicated R20 required extensive assistance with all ADLs. The CAA ident was at risk for contractures as a complication immobility. Continued staff assist with AI mobility each shift would be care planned to avoid complications and referrals to ot disciplines was not warranted. Existing contractures were not identified on the C. R20's care plan last revised 11/29/21, inc R20 had Parkinson's disease and directe encourage exercise and mobility. Staff w report any improvement or decline to the physician. The care plan also identified I limited physical mobility related to his Pardisease and dementia. Staff were direct monitor and document signs and sympto immobility, contractures forming or worse and skin breakdown. The care plan lacke identification R20 had a contracture to his hand, as well as interventions of placing guard in R20's left hand. In addition, the lassistant (NA) care sheet dated 1/3/22, ladirection for use of a palm protector. On 3/9/22, at 3:37 p.m. and on 3/10/22, a a.m. R20 was observed sitting in his whe with a palm protector in place in his left he During interview on 3/10/22, at 10:15 a.m occupational therapist aide (OTA)-A state was not aware R20 used a palm protector.	tance 20 had side on te. dated e iffied R20 ation of DLs and d in order hers AA. dicated ed staff to ere to R20 had rkinson's ed to ms of ening ed s left a palm nursing acked at 8:20 el chair and. n. ed she				

Minnesota Department of Health

STATE FORM 6899 07UP11 If continuation sheet 4 of 26

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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2 565	Continued From pa	ge 4		2 565			
	OTA-A felt it must hintervention. She diprotector had been When interviewed diassistant director or had implemented the but was unsure who initiated.	pave been a noil not know which implemented on 3/9/22, at 1 for nursing (AD) ne sheepskin	vhen the palm l. 1:26 p.m. ON) stated they palm protector				
	During interview on director of nursing of did not address into contracture to his le NA care sheets sho include the use of t	(DON) stated erventions to t eft hand and t ould have bee	R20's care plan treat R20's he care plan and n updated to				
	The facility policy Care Plan Reviews/Conferences with revision date May 2020, indicated the care plan conference was an interdisciplinary process and provided an in-depth review of the residents plan of care.						
	R10's Admission Ridentified diagnoses Mellitus, chronic dia condition in which that as well as it should spinal stenosis (a column narrows puthe spinal column), right upper extremit disease in at least the pain, restricted move	s that included astolic heart factoric heart does he morbid obe ondition in whatting pressure carpal tunnelty, and polyosive joints with	d Diabetes ailure (a chronic sn't pump blood sity, lumbar nich the spinal e on the nerves in syndrome of the steoarthritis (joint inflammation,				
	R10's admission M 1/20/22, indicated F adequate vision and assistance with AD of bowel and bladd	R10 was cogn d hearing, rec Ls, was frequ	nitively intact, had quired extensive ently incontinent				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00587					C 10/2022	
	PROVIDER OR SUPPLIER	200 W	FADDRESS, CITY,				
BOONDA	ANT WATERS CARE C	ELY, I	IN 55731				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 565	Continued From pa	ige 5	2 565				
	medications in the plant for developing pres	past five days, and was at ri sure ulcers.	sk				
	1/20/22, triggered p (physical immobility and pressure ulcer/	ssessment (CAA) dated potential for ADL decline /), urinary incontinence, falls /injury. The analysis of findir / would care plan in these					
	indicate potential co chronic congestive pain related to lumb polyosteoarthritis, a	and carpal tunnel syndrome, ance with ADLs, or his poten					
	The nursing assistant care guide undated, indicated R10 as incontinent of bowel and bladder.						
	measure risk of ski indicated R10 score summary was as fo	assessment (a tool to n impairment) dated 1/14/22 ed 16 (mild risk). The ollows: at risk for skin nly make slight movements oladder.	2,				
	9:40 a.m. indicated chronic issues with	ogress note dated 2/28/22, a R10's only complaint was the the neuropathy in his hands na was noted in R10's	ne				
		o.m. R10 was seated in his he had pain in his hands.					
		o.m. R10 was seated in his					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED		
00587			B. WING			D 1 0/2022	
NAME OF F	PROVIDER OR SUPPLIER	ST	REET ADI	DRESS, CITY, S	STATE, ZIP CODE	·	
BOUNDA	ARY WATERS CARE O	ENTER	0 WEST Y, MN	CONAN ST 55731	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 6		2 565			
	hurting.						
	(DON) stated R10's identification, goals pain, pressure ulce verified nursing was	p.m. the director of nurs s care plan lacked , or interventions for ede rs, and ADLs. The DON s responsible for comple esidents care plan was	ema,				
	indicated the care p be quarterly and as	tled Care Plan - ces revision date 5/2020 plan review/conference v needed and would prov he resident's plan of car	vould ride an				
	The Director of Nur develop, review, an procedures to ensu centered comprehe interventions to ass symptoms related to The Director of Nur educate all appropri procedures. The Director of Nur	THOD OF CORRECTION ising or designee could don revise policies and the residents have personable cae plans to include ess and treat resident to their diagnoses, sing or designee could itate staff on the policies are systems to ensure ongo	n de and				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twen	ty-one				
2 890	MN Rule 4658.0529 Motion	5 Subp. 2 A Rehab - Rar	nge of	2 890			4/8/22
	that is directed towa	motion. A supportive pr ard prevention of deform and range of motion mu	ities				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		00587	B. WING		I	C 10/2022
	F PROVIDER OR SUPPLIER	CENTER 200 WE	ADDRESS, CITY, ST CONAN S' N 55731	STATE, ZIP CODE TREET		
(X4) IE PREFI TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 89	implemented and no comprehensive ressof nursing services development of a nursing service that: A. a resident without a limited rail experience reduction that a reduction in unavoidable; and This MN Requirements: Based on observation review, the facility function (ROM) service who had identified by fingers and thumber decrease in ROM. Finding include: R20's annual Minimal 7/26/21, indicated Fincluded Parkinson diabetes. R20 requitotal assist with all and mobility. R20 hupper extremities and ROM of both lower R20's quarterly MD R20 had diagnoses disease, dementia, cognitive impairments.	naintained. Based on the ident assessment, the director must coordinate the dursing care plan which who enters the nursing home ange of motion does not on in range of motion unless al condition demonstrates range of motion is ent is not met as evidenced ion, interview and document failed to provide range of rices for 1 of 3 residents (R20 ROM limitations in his left and had sustained a potential rum Data Set (MDS) dated R20 had diagnoses that 's disease, dementia, and ired extensive assistance to areas of daily living (ADLs) and no ROM impairments to hand had impairments to his) is	Corrected.		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILDING.			
		00587	B. WING		I	0/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BOUNDA	ARY WATERS CARE (CENTER 200 WEST	Г CONAN ST 55731	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 890	1/22/22, indicated Fincluded Parkinson diabetes. R20 had and required extensactivities of daily livhad impaired ROM extremities and am R20's activities of CASSESSMENT (CAA) required extensive people and use of the transfer and was not functional status was plan to avoid compidentification of any extremities. R20's Pain Assessing 1/21/22, indicated Fince R20's Occupational Summary dated 8/2 being discharged find fremain residing in the excellent to maintal with consistent staff recommendations of the upper expliving. Review of One 7/30/20, to discharge activities of the upper expliving. Review of One of the upper explicitly and the proper explicitly of the upper explici		2 890	DEFICIENCY)		
	concerns related to R20's Physical The	rapy (PT) Discharge Summary				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				A. BOILDING.		,	c
		00587		B. WING			10/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BOUND	ARY WATERS CARE (CENTER	200 WEST ELY, MN	Γ CONAN ST 55731	REET		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 890	Continued From particles and set at 8/28/20, indicambulate a few feet the parallel bars. Recurrent level of funds taff follow through were for R20 to cor and sitting at the edstrength. Review of services 7/28/20, to 8/28/20, lacked ide or concerns related and Parkinson's disencourage exercises perform ADLs and decline to the physisymptoms of Parking included poor balar cramps or rigidity, a plan identified R20 related to his Parking Staff were directed signs and symptom forming or worsening care plan lacked idcontracture, as well guard to this left has R20's progress not were reviewed, whin R20's contracted (Amuscles, tendons, causes the joints to stiff. This prevents other body part) le 2/18/22, was the fir symptoms of pain a contracture. This prevents other body part or resistence.	cated R20 was t with moderate 20's prognosis ction was good . Discharge recentinue his home dige of the bed of PT notes from of discharge from of discharge from of the R20's left had ted 11/29/21, in sease and direct es and to monit report any import cian. Staff were conson's complication. Staff were conson's complication of the had limited phy conson's disease to monitor and discomplication to monitor	e assistance in to maintain his with consistent commendations e exercise plan for core in initiation of m services and. Indicated R20 cted staff to tor for ability to rovement or e to monitor for ations which dination, muscle ROM. The care ysical mobility and dementia. I document r, contractures eakdown. R20's his left hand his such as palm 21, to 3/8/22 tification of ghtening of the by tissues that ecome very tent of a joint or ress note dated R20 showing to left hand so indicated	2 890			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
00587			B. WING		I	C 10/2022	
NAME OF	PROVIDER OR SUPPLIER		ET ADDRESS, CITY,				
BOUND	ARY WATERS CARE C	ENIER	WEST CONAN S MN 55731	TREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 890	Continued From pa	ge 10	2 890				
	progress notes, ord sheets regarding in guard. A progress note dat was seen by a physicontracture and a rewas received. Althothere no documents	e was no indication in R20' lers, care plan or aide care itiation or use of the palm ted 2/22/22, indicated R20 sician for his left hand pain eferral for a surgery consuough R2 was palm guard, ation in notes, care plan or	and It				
	aide sheet related to use of a palm guard. Physician clinic visit note dated 2/22/22, indicated R20 was first seen for contracture to his left hand with complaints of pain. The physician indicated he was going to make a surgical referral for injection for this type of issue and he would get that set up. The physician indicated amputation could also be considered.						
	in a reclined position left hand was resting left hand was tightly with his pointer fing remaining three fing nails were pressed his thumb curled tigunable to turn his hip palm face up. He signs was no positioning	o.m. R20 was observed site in in a recliner in his room. In g palm down on his lap. To y contracted in a fist position er rigidly fully extended. The gers were tightly closed and into the palm of his hand with the palm of his hand independently to have stated his hand hurt. There devices in place for his left do no devices were visible in the palm of his left do no devices were visible in the palm of th	His he				
	sitting in the dining a soft palm guard p unable to turn his h fingers of his left ha	a.m. R20 was observed room eating breakfast. He placed in his left hand. He and to face upward and the and appeared tightly R20 stated his left hand	was e				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X	(3) DATE			
			A. BUILDING:			0		
		00587		B. WING			03/1	0/2022
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE			
BOUNDA	ARY WATERS CARE O	ENTER	200 WEST ELY, MN	Γ CONAN ST 55731	REET			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD B HE APPROPRI		(X5) COMPLETE DATE
2 890	Continued From pa	ge 11		2 890				
	and was worse whe	en touched.						
	During interview on assistant (NA)-A stacontracted but it ha would become more move or even touch the palm guard. Natell it bothered R20 stated nursing did residents. Exercise During joint interviee (DON) and the assi (ADON) on 3/9/22, the facility staff did They did not have a residents and they at the rapy regarding Fassessments for the asshe had been try them to be completed not been done on Fand the ADON was assessment had be DON stated R20's owas not identified oproblem with intervicidentified.	ated R20's led recently go e agitated which has left han A-A indicated more than it not do ROM es were done which with the distant director at 1:26 p.m. not do ROM program a ROM program to figure ed. A ROM 220 since be unsure where contracture to his care plentions should	eft hand had been often worse. R20 when they tried to ad and he resisted dryou could really that had before. NA-A exercises with ere by therapy. Irector of nursing or of nursing or of nursing the ADON stated with residents. From for any of their liking more with the ere out a way for assessment had fore July 2021, the last ROM					
	During interview on occupational therapassisted residents of the therapist had consetup the program. 7/30/20, through 8/2 admitted to the facilibut she was never a contracture and OT palm guard for his I	oist aide (OT. with their OT ompleted the She had wo 28/20, when lity. His han made aware had not imp	A)-A indicated she exercises after excreening and orked with R20 he was first d was a little tight, a R20 had a plemented the					

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STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		С	
		00587	B. WING			0/2022
NAME OF PROVIDER OR SUP	PLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BOUNDARY WATERS CA	ARE (CENTER 200 WEST	T CONAN ST 55731	REET		
PREFIX (EACH DEFI	CIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
was not aware his hands. If F she would have involved OT. massage, war may have help avoided a sure. On 3/10/22, are attempting to R20 immediate grimace. R20 arm in full extended to face proceedings on his was unable to the skin of his would have halleft hand in ordocumented in 2020 through been able to go his left hand whis hand had sweeks. The facility po 2020, indicate maintain or at functioning. A admission and possible inclusing Restorative proceders and single possible inclusions and single possible inclusions. The facility possible inclusions and single possible possible inclusions and single possible pos	plema e R20 R20 w ve the OTA- rm so ped a 1 gical of to left h o get to left ped to ranguage starte olicy R ed at e starte olicy R ed at e starte	ented the palm guard as she) was having any issues with was having pain in his hand, bught nursing would have -A indicated sometimes gentle baks and other interventions and could have possibly	2 890			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. BOILBING.		С	
00587		00587	B. WING		03/10/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BOUNDA	ARY WATERS CARE O	CENTER 200 WEST	Γ CONAN ST 55731	REET		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 890	Continued From pa	ge 13	2 890			
	provide physical, occupational and speech therapy to attain or maintain function and/or prevent decline with a physician ordered treatment plan.					
	SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents receive range of motion services to prevent loss of function. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one					
2 940	(21) days. MN Rule 4658.0525 Subp. 9 Rehab - Hydration Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted.		2 940			4/8/22
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to reduce or prevent continued weight loss for 1 of 2 residents (R17) reviewed for nutrition and sustained a weight loss of 18 pounds in a two month period. Findings include:			Corrected.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00587	B. WING		l l	C 10/2022	
NAME OF PROVIDER OR SUPPLIER			TATE, ZIP CODE			
BOUNDARY WATERS CARE C	ENTER 200 WEST	Г CONAN ST 55731	REET			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
(MDS) 1/28/22, ider including atrial fibrill hypertension, kidner (the lower portion of due to acid reflux di clostridium difficile. required supervision was recorded as 64 recorded at 160 pour a weight gain or loss. R17's Physician Ord R17 was to receive soft texture diet. R17's Care Plan with nutritional or dietary were documented. R17's Nutritional Cardated 2/8/22, indicar room and was a "pide experiencing some requested small me problems chewing in consumption was to weights weekly. A redietician was indicated on 1/20/22, a dietar R17's status was re 163 pounds (lbs) on 159 lbs. Another we ensure no further with meals was 50-100 p.	ange Minimum Data Set ntified R17 had diagnoses ation (irregular heart beat), y disease, Barretts esophagus f the colon thick and inflamed sease), and entercolitis due to R17 had intact cognition and n with eating. R17's height inches and her weight was unds. The MDS did not identify had occurred. Iders dated 3/10/22, indicated a no added salt, mechanical the print date 3/10/22, lacked a refocus and no interventions Are Area Assessment (CAA) ted R17 ate her meals in her cky eater". She had been nausea and pain and eals. She identified having meat at times. Meal be monitored daily and referral to a registered ted for a full assessment. Ty progress note indicated viewed. Her initial weight of a 1/4/22, was down "a bit" to eight was recommended to eight loss. R17's intake at	2 940				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G:		(X3) DATE SURVEY COMPLETED		
		00587	B. WING _	B. WING		C 03/10/2022	
	PROVIDER OR SUPPLIER	200 \	ET ADDRESS, CITY	, STATE, ZIP CODE			
ВООПЪ	ANT WATERO DANE C	ELY,	MN 55731				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 940	Continued From pa	ge 15	2 940				
	per day. Staff were	vell as supplements two ting to encourage meal intake ould add R17 to her month	s				
		Results listing dated from o 3/7/22, identified the weights for R17:					
	- On 1/4/22, R17 we	eighed 162 lbs;					
	- On 1/7/22, R17 we	eighed 159 lbs;					
	- On 2/17/22, R17 v	weighed 141 lbs, and					
	-On 3/7/22, R17 we weight loss in 60 da	eighed 144 lbs. (an 18 lb. ays).					
	R17's medical record was reviewed and lacked any evidence R17 had been comprehensively reassessed or evaluated for this loss of weight, and there was no evidence any new interventions were being screened or implemented to help prevent or slow the continued loss of weight. The recommended twice a day supplements had not been implemented as recommended by the dietician.						
	When interviewed on 3/10/22, at 9:36 a.m. nursing assistant (NA)-B stated R17 frequently had an upset stomach, so she sometimes did not eat well. If they noticed a weight loss, they would notify the nurse, however, they were unable to compare a resident's weight to the previous weight or track weights. They just turned in the bath sheet with the resident's current weight and the nurse would enter and track the weights.						
		w with licensed practical not on 3/10/22, at 9:43 am.	urse				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			71. 501251110.		c	
		00587	B. WING			0/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BOUND	ARY WATERS CARE (CENTER 200 WES' ELY, MN	T CONAN ST 55731	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 940	LPN-A stated the n weights into the characteristic they would then not (DM)-A. The prograwing weight loss or gain weight, otherwise it inform nursing of the Nursing would get a supplements on the record (MAR). LPN aware R17 had a werbally notified the the loss in weight, do any needed follow. When interviewed to DM-A stated the discould always contanged by the complaints of naus going to have an erpounds back last we things were improved mup. DM-A was nursing staff of the day dietary supplements of the day dietary supplements and it should he daily interdisciplinativould typically reviewed to the proposition of the day dietary supplements and it should he daily interdisciplinativould typically reviewed to the supplements and it should he added, he weight to the supplements and it should be added, he weight to the supplements and it should be added, he weight to the supplements and it should be added, he weight to the supplements and it should be added, he weight to the supplements and it should be added, he weight to the supplements and the supplements and the supplements are the supplements and the supplements and the supplements are the supplements are the supplements and the supplements are the supplements and the supplements are the supplements and the supplements are the supplemen	urses entered the weekly bath art. If a weight discrepancy m would flag and warn them. of tify the dietary manager am would flag a 5% or greater from the previous weeks would not flag. DM-A would be need for supplements. an order and schedule the emedication administration N-C indicated she was made veight loss and she had edirector of nursing (DON) of She had left it with the DON to bow up on it. On 3/10/22, at 10:01 a.m. etician came monthly, but they cat her by phone if needed. If R17's weight loss and had er and adding extra food to her and adding extra food to her and adding extra food to her and adding like she was mesis. R17 had gained two week and DM-A was confident ing. When the dietician plements, nursing was anining the order and setting so not sure if she had informed recommendation for twice a	2 940			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
	00587		B. WING	B. WING		C 10/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE	·	
BOUNDA	ARY WATERS CARE O	SENTER	T CONAN ST	TREET		
040.15	CLIMANA DV CTA	ELY, MN		DDOVIDEDIC DI ANI OF CODI	PECTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 940	Continued From pa	ge 17	2 940			
	supplements should recommended by the physician should had resident's weight lo notified him of a resident's with DM-A. The facility policy WM May 2020, indicated residents who enteresidents	d have been ordered as the dietician and R17's ave been notified of the ss. Typically when staff sidents weight loss, he would A and notify the physician. Veight Loss with review date d the facility would ensure red the facility would not fall ady weight range, unless it was able. Residents identified as a would be noted on their care ized interventions. Dietary completed and suggestions ary or designee and nurse's				
	suggested Method of Correction: Suggested Method of Correction: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to reduce or prevent continued weight loss for residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one					
21285		O Subp. 2 Admission Orders	21285			4/8/22
	and Physician Eval Subp. 2. Admissio must have physicia					

Minnesota Department of Health

Minnesota Department of Health						
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00587	B. WING		1	0/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TW WILL OT	200 WES					
BOUNDA	ARY WATERS CARE O	CENTER ELY, MN		KLLI		
040.15	CLIMMA DV CTA			DDOVIDEDIC DI ANI OF CODDECTIO		()(5)
(X4) ID PREFIX	-	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
21285	Continued From pa	ge 18	21285			
	admission.					
	aumission.					
	This MN Requireme	ent is not met as evidenced				
	by:					
		and document review the		Corrected.		
		nin physicians orders/guidance				
		(R17) who had sustained a				
		ess and recommendations for				
		nents. In addition, the facility sician orders/guidance for 1 of				
		ho had orders for physical				
		veekly and who would not be				
	receiving therapy se					
	Findings include:					
	R17's significant ch	ange Minimum Data Set				
	(MDS) 1/28/22, idea	ntified R17 had diagnoses				
		lation (irregular heart beat),				
		ey disease, Barretts esophagus				
		f the colon thick and inflamed				
		isease), and entercolitis due to R17 had intact cognition and				
		n with eating. R17's height				
		inches and her weight was				
	recorded at 160 por	•				
	1	ders dated 3/10/22, indicated				
		a no added salt, mechanical				
	soft texture diet.					
	P17's Care Plan wit	th print data 3/10/22 lacked a				
		th print date 3/10/22, lacked a / focus and no interventions				
	were documented.	, 10003 and 110 litter vertions				
	word accumented.					
	R17's Nutritional Ca	are Area Assessment (CAA)				
		ated R17 ate her meals in her				
		cky eater". She had been				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00587	B. WING			C 10/2022	
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
BOUNDARY WATERS CARE C	ENTER 200 WES ELY, MN	T CONAN STE 55731	REET			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
requested small me problems chewing in consumption was to weights weekly. A redictician was indicated on 1/20/22, a dietar R17's status was red 163 pounds (lbs) on lbs. Another weight no further weight los 50-100 percent. On 2/17/22, a dietar continued to have a was now down to 13 recommended as well per day. Staff were thank the dietician wo reviews. R17's Search Vitals admission 1/4/22, to following recorded well on 1/7/22, R17 well on 1/7/22, R17 well on 2/17/22, R17 well weight loss in 60 day. R17's medical recording recorded well and there was no evidence R17 heassessed or evaluation and there was no evidence was no eviden	nausea and pain and als. She identified having neat at times. Meal be monitored daily and eferral to a registered fied for a full assessment. Ty progress note indicated viewed. Her initial weight of 1/4/22, was down a bit to 159 was recommended to ensure ss. R17's intake at meals was by progress note indicated R17 weight loss and her weight loss and her weight as supplements two times to encourage meal intakes all as supplements two times to encourage meal intakes and add R17 to her monthly Results listing dated from 3/7/22, identified the weights for R17: Seighed 162 lbs. Seighed 159 lbs, Weighed 141 lbs, and					

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			71. 501251110.		c	
		00587	B. WING		I	0/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BOUNDA	BOUNDARY WATERS CARE CENTER 200 WES ELY, MN			REET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21285	Continued From pa	nge 20	21285			
	prevent or slow the recommended twic been implemented dietician.	continued loss of weight. The e a day supplements had not as recommended by the				
	practical nurse (LP aware R17 had a w verbally notified the	a 3/10/22, at 9:43 a.m. licensed N)-C indicated she was made weight loss and she had e director of nursing (DON) of She had left it with the DON to bow up on it.				
	When interviewed on 3/10/22, at 10:01 a.m. DM-A stated when the dietician recommended supplements, nursing was responsible for obtaining the order and setting them up. DM-A was not sure if she had informed nursing staff of the recommendation for twice a day dietary supplements.					
	DON stated he had loss and it should he daily interdisciplinal would typically revieloss at IDT meeting should be added, he done regarding R1 supplements should recommended by the physician should he resident's weight lonotified him of a resident and it is should the resident and it is should he resident	I 3/10/22, at 9:55 a.m. the I heard about R17's weight have been discussed at the ry team meeting (IDT). They ew any residents with weight gs and discuss if a supplement however, nothing had been 7's loss of weight. R17's d have been ordered as the dietician and R17's have been notified of the less. Typically when staff sidents weight loss, he would A and notify the physician.				
	May 2020, indicate residents who ente below their ideal bo	Veight Loss with review date d the facility would ensure red the facility would not fall ody weight range, unless it was able. Residents identified as at				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
				A. BUILDING.			c	
		00587		B. WING			10/2022	
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BOUNDA	ARY WATERS CARE (CENTER	200 WEST ELY, MN	Γ CONAN ST 55731	REET			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
21285	Continued From parisk for weight loss plan with individual consults would be implemented. Diet notes would address physician would be residents with docurecord.	would be no ized interven completed an ary or design se weight los made aware	ntions. Dietary and suggestions anee and nurse's and sissues. The and of at risk	21285				
	R282's undated Admission Record identified R282 was admitted to the facility 2/24/22, with diagnoses including fracture of the right lower leg, diabetes, multiple myeloma, anxiety, weakness, abnormal gait and muscle spasms. R282's Active Order Summary Report dated 3/10/22, indicated Physical Therapy (PT) and Occupational Therapy (OT) were to evaluate and treat as ordered.							
	R282's Activities of Assessment (CAA) required assistance due to a recent righ non weight bearing risk for falls. PT ar for strengthening, r awareness.	dated 3/4/2. with his AD at ankle fract to his right I ad OT service	2, identified R282 Ls and mobility ure and he was eg. R282 was at es were ordered					
	R282's PT Evaluation 2/25/22, identified in the properties exercise reeducation, gait transcriptions five times	R282 would l es, neuromu aining therap per week fo	be seen for iscular by, and therapeutic r thirty days.					
	R282's PT visit not 3/9/22, were provided 2/25	ed and iden	tified PT services					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00587	B. WING		I	C 10/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
BOUNDA	ARY WATERS CARE O	ENTER 200 WES	T CONAN ST 55731	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21285	Continued From particles of 3/3/22 and 3/7/22. Completed on 3/4/2. When interviewed on stated he was not rewasted he was not rewasted and he time. During interview on occupational therapted facility usually has purely through Friday but to (PTA)-A was off for physical therapist we two times per week scheduled exercised days. During interview on director of nursing (not making visits with would need to notify missed visits and of aware the PTA-A was and he would notify missed visits now. The facility policy N Physician/Family?R Change in Residented the November 2011 notify the physician alter treatment sign SUGGESTED MET	ge 22 No therapy visit had been 2, 3/8/22, and 3/9/22. on 3/7/22, at 3:46 p.m. R282 eceiving therapy as often as a was in his bed most of the 3/10/22, at 8:29 a.m. by aide (OTA)-A stated the ohysical therapy daily Monday the physical therapy aide two weeks. OTA-A stated the rould be coming to the facility and would do PTA-A s with the residents on those 3/10/22, at 2:54 p.m. the DON) stated if therapy was the a resident as ordered they are the primary physician of the btain new orders. He was as not working for 2 weeks R282's physician of the confication to desident Representative of the Health Status with revision 16, indicated the facility would whenever there was a need to difficantly.	21285			
	develop, review, an procedures to ensu orders/guidance to	sing or designee could d/or revise policies and re staff obtain the needed prevent significant weight facility could ensure a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X) A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00587	B. WING			C 03/10/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BOUNDA	ARY WATERS CARE O	ENTER 200 WES ELY, MN	Γ CONAN ST 55731	REET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
21285	out as ordered. The Director of Nureducate all approprious procedures. The Director of Nurdevelop monitoring compliance. TIME PERIOD FOR (21) days.	e resident's orders are carried sing or designee could iate staff on the policies and sing or designee could systems to ensure ongoing R CORRECTION: Twenty-one	21285			4/8/22	
	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.					,, 0, 22	
	This MN Requireme	ent is not met as evidenced					

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Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
				71. 501251110.		С	
		00587		B. WING			0/2022
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BOUNDA	ARY WATERS CARE C	ENTER	200 WEST ELY, MN	Γ CONAN ST 55731	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	Continued From particles by: Based on interview facility failed to ensity (activities [A], dieate assistant [NA]-C) which tuberculosis signs a facility failed to complete the test (TST) for 4 of 5 LPN-B, NA-C). This 32 residents residing Findings include: Personnel records of reviewed and the form of the test (TST) for 4 of 5 LPN-B, NA-C). This 32 residents residing Findings include: Personnel records of reviewed and the form of the test of the	and document revieure 3 of 5 employees ary aide [DA]-B, nurere properly screen and symptoms. In a uplete a 2-step tube is employees (A-A, Es had the potential tog in the facility. The five newly hired sollowing was found: In the facility. The five newly hired sollowing was found: In the facility. The five newly hired sollowing was found: In the facility. The five newly hired sollowing was found: In the facility. The five newly hired sollowing was found: The five newly hired sollowing	es sing led for ddition, the rculin skin DA-B, o affect all staff were wever, a was not tep one dence of a however, losis led. DA-B there was hired 22, but the step TST. 1/15/22, of screening size.	21426	1. Activities (A), Dietary Aide (DA) nursing assistant (NA)-C will be p screened for tuberculosis signs a symptoms. 2. Employees A-A, DA-B, LPN-B in NA-C will complete a 2-step tuber skin test. 3. DON or designee will develop a prevention program that ensures employees have a baseline screed done. 4. All staff members will be audited ensure that a baseline screening 2-step tuberculin skin test are conformation of the staff will be conformation. 5. Audits of all new staff will be conformation. 6. Results will be reviewed in mor QAPI and changes will be made an ecessary. 7. Date certain April 8, 2022.	and reculin a TB all new ening ed to and mpleted. ompleted athly for 2	

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STATE FORM 6899 07UP11 If continuation sheet 25 of 26

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00587	B. WING			C 1 0/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BOUNDA	ARY WATERS CARE C	ENTER 200 WES' ELY, MN	T CONAN ST 55731	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21426	completed for other paperwork may have The facility's Facility Assessment for He baseline TB screen hire for all health cascreening includes: of active TB disease testing for the preseadministatering eith TB blood test. SUGGESTED MET The director of nurse develop, review, an program and ensure baseline screening	reasons or some of the ve been discarded. y Tuberculosis Risk alth Care Settings identified ing is required at the time of are personnel. Baseline TB an assessment for symptoms e, assessing TB history, ence of infection by are a two-step TST or single THOD OF CORRECTION: sing (DON) or designee could d/or revise the TB prevention e new employees have a	21426			

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Minnesota Department of Health STATE FORM

PRINTED: 05/17/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION 01	` '	E SURVEY IPLETED
		245138	B. WING			03/	08/2022
NAME OF PROVIDER OR SUPPLIER BOUNDARY WATERS CARE CENTER				2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST CONAN STREET ELY, MN 55731		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	KC	000			
	FIRE SAFETY						
	conducted on 03/0. Department of Pub Division. At the tim Waters Care Cente with the requirement Medicare/Medicaid 483.70(a), Life Safedition of National (NFPA) Standard 1 Chapter 19 Existing	ty recertification survey was 8/2022 by the Minnesota blic Safety, State Fire Marshal e of this survey, Boundary er was found not in compliance nts for participation in at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), g Health Care and the 2012, The Health Care Facilities					
	ALLEGATION OF ODEPARTMENT'S ASSIGNATURE AT THE PAGE OF THE CM	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE.					
	ONSITE REVISIT (CONDUCTED TO SUBSTANTIAL CO REGULATION HAS	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE S BEEN ATTAINED IN ITH YOUR VERIFICATION.					
		E AN EPOC, A PAPER COPY CORRECTION IS NOT					
	PLEASE RETURN						
I ABORATORY	/ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE		TITLE		(X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED		
		245138	B. WING			03/0	08/2022
NAME OF PROVIDER OR SUPPLIER BOUNDARY WATERS CARE CENTER				20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST CONAN STREET LY, MN 55731		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	DEFICIENCIES (K HEALTH CARE FIRSTATE FIRE MARS 445 MINNESOTA S ST. PAUL, MN 551 By e-mail to: FM.HC.Inspections THE PLAN OF COLDEFICIENCY MUS FOLLOWING INFO 1. A detailed descritaken or planned to 2. Address the meato ensure the deficit 3. Indicate how the performance to ensure the deficit 4. Identify who is reactions and monito 5. The actual or prothe remedy. The Boundary Watebuilding with no bas constructed in 1968 Both buildings are constructed.	R THE FIRE SAFETY TAGS) TO: RE INSPECTIONS SHAL DIVISION STREET, SUITE 145 01-5145, or @state.mn.us RRECTION FOR EACH TINCLUDE ALL OF THE DRMATION: ption of the corrective action of correct the deficiency. assures that will be put in place ency does not reoccur. facility plans to monitor future sure solutions are sustained.	KO	000			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 245138 B. WING 03/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **200 WEST CONAN STREET BOUNDARY WATERS CARE CENTER** ELY, MN 55731 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 000 | Continued From page 2 K 000 The building has an automatic sprinkler system installed throughout and also has a fire alarm system with smoke detection throughout the corridor system and in the common spaces. The facility has a capacity of 42 beds and had a census of 32 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET. K 351 Sprinkler System - Installation K 351 4/8/22 SS=D CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations, documentation review, 1. Storage in the activities' storage room and staff interview, the automatic sprinkler will be removed so that the sprinkler head system is not maintained per the 2012 edition of has more than 6 inches of clearance.

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OLIVILI	TO TOTA MEDIONIA	& MEDICAID SERVICES				INO.	0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (2)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IULTIPLE CONSTRUCTION ILDING 01		E SURVEY IPLETED	
		245138	B. WING	i		03/	08/2022	
NAME OF F	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
BOUNDARY WATERS CARE CENTER					200 WEST CONAN STREET ELY, MN 55731			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
K 363 SS=D	National Fire Prote Standard 101, Life and NFPA 13 (201 Installation of Sprin This deficient findir impact on the resid Findings include: On 03/08/2022, at observation that the located in the activil lounge was within 6 deflector that is loc. An interview with the verified this deficient discovery. Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting correquired enclosures hazardous areas reand are made of 1 wood or other mate at least 20 minutes smoke compartme the passage of smoto rooms containing materials have poslatches are prohibit requirements do not contain flam Clearance between covering is not exception.	age 3 ction Association (NFPA) Safety Code, section 9.7.5, 0 edition), Standard for the lkler Systems, section 8.5.6.1. Ing could have an isolated lents within the facility. 1:30 PM, it was revealed by the height of the storage that is lities storage room by the tities storage room by the tities storage room by the tities and the sprinkler head attend within that room. In Maintenance Supervisor and finding at the time of the Porridor openings in other than as of vertical openings, exits, or the esist the passage of smoke 3/4 inch solid-bonded core terial capable of resisting fire for and Doors in fully sprinklered and the sare only required to resist boke. Corridor doors and doors and floor and by CMS regulation. These to the apply to auxiliary spaces that and bottom of door and floor and floor and inch. Powered doors and are permissible if provided		351	 All store rooms will be audited to ensure items are not stored to clos sprinkler heads. Audits or store rooms will be corby the Administrator or his designer per week times two weeks, 1x per for two weeks and then monthly for additional months. Results of these audits will be reat monthly QAPI meetings and chawill be made as necessary. Date certain April 8, 2022. 	nducted ee 2x week r two	4/8/22	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 245138 B. WING 03/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **200 WEST CONAN STREET BOUNDARY WATERS CARE CENTER** ELY, MN 55731 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 363 | Continued From page 4 K 363 with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, This REQUIREMENT is not met as evidenced Based on observation and staff interview, the 1. A magnetic hold open device that releases when the door is pushed or facility had 1 of numerous corridor doors that were not maintained per NFPA 101 (2012 pulled will be installed on the edition), Life Safety Code, sections 19.3.6.3, Administrator's office door. 19.3.6.3.10, and 19.3.6.3.11. This deficient 2. Date certain April 8, 2022. finding could have an isolated impact on the residents within the facility. Findings include: On 03/08/2022, at 1:53 PM, it was revealed by observation that the corridor door to the administrator's office was being propped open with a disconnected and rolled-up power charging block and cord. An interview with the Maintenance Supervisor

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		245138	B. WING		03/0	03/08/2022	
NAME OF PROVIDER OR SUPPLIER BOUNDARY WATERS CARE CENTER				STREET ADDRESS, CITY, STATE, Z 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	REFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
K 918 K 920 SS=D	interview, the facilithe emergency ge edition), Life Safe NFPA 110 (2010 e Emergency and S 8.4.2. This deficie isolated impact or Findings include: On 03/08/2022, at review of available inspection docum the Maintenance of provided incomple 2021 monthly emetest/inspection, who beerved condition values for that test An interview with the verified this deficied discovery. Electrical Equipme CFR(s): NFPA 10 Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble.	lity failed to test and maintain enerator per NFPA 101 (2012 ty Code, section 9.1.3.1, and edition), Standard for standby Power Systems, section not finding could have an a the residents within the facility. It 11:44 AM, it was revealed by a second energency generator test and entation and an interview with Supervisor that the facility ete documentation for the April ergency generator nich did not contain the ns and recorded operational its and inspection. Ithe Maintenance Supervisor ent finding at the time of the ent - Power Cords and Extens 1 ent - Power Cords and entation care vicinity are only	K 918	tests/inspections will conconditions and recorded values for all tests and in 2. Monthly emergency getests/inspections will be a Maintenance Supervisor monthly x3. 3. Results of these audits at monthly QAPI meeting will be made as necessa 4. Date certain April 8, 20	operational spections. enerator audited by the or designee s will be reviewed and changes ry.	4/8/22	

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