DEPARTMENT OF HEALTH

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 Therefore, the NATCEP prohibition is rescinded.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

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Protecting, Maintaining and Improving the Health of All Minnesotans

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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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245138	A. BUILDING _____ B. WING _____	C 03/10/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/7/22, through 3/10/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041		4/8/22

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

Electronically Signed | 03/31/2022

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E 041	Continued From page 1 must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the	E 041		

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E 041	Continued From page 2 availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to test and maintain the emergency generator per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life	E 041	1. Monthly emergency generator tests/inspections will contain observed conditions and recorded operational values for all tests and inspections.	

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E 041	Continued From page 3 Safety Code, sections, 9.1.3, and the 2010 edition of National Fire Protection Association (NFPA) Standard 110, Standard for Emergency and Standby Power Systems, section 8.4.2. This had the potential to affect all 32 residents residing in the facility. Findings include: On 3/8/22, at 11:44 a.m. a review of inspection and documentation records showed there was incomplete documentation of the April 2021 monthly emergency generator test/inspection. The documention lacked the observed conditions and recorded operational values for that test/inspection. The maintenance supervisor verified the deficient practice at the time for the document review.	E 041	2. Monthly emergency generator tests/inspections will be audited by the Maintenance Supervisor or designee monthly x3. 3. Results of these audits will be reviewed at monthly QAPI meetings and changes will be made as necessary. 4. Date certain April 8, 2022.	
F 000	INITIAL COMMENTS Surveyor: Johnson, Colleen On 3/7/22, through 3/10/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F886 when the facility failed to ensure that staff who had symptoms of COVID-19 were tested with a confirmatory real-time reverse transcription polymerase chain Reaction (RT-PCR) test, according to CDC guidance. The IJ began on 1/10/22, and the immediacy was removed on 3/9/22.	F 000		

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F 000	Continued From page 4 The following complaint was found to be UNSUBSTANTIATED: H5138043C (MN65426, MN65547, MN65547). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 609		4/8/22

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F 609	Continued From page 5 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report bruising of unknown origin to the State Agency (SA) according to Federal regulations for 1 of 1 residents (R20) reviewed for abuse. Findings include: R20's quarterly Minimum Data Set (MDS) dated 1/22/22, indicated R20 had diagnoses that included Parkinson's disease, dementia, and diabetes. R20 had severe cognitive impairment and required extensive assistance to complete all activities of daily living (ADLs). R20's care plan with revision date of 11/29/21, indicated he required assistance of one to two staff with dressing, grooming, toileting, bed mobility and transfers. Staff were to use a mechanical stand with transfers. The care plan indicated an individual abuse prevention plan because R20 had moments of aggression that included verbal and physical towards staff. Staff were to monitor for all injuries and discuss in the interdisciplinary team meetings (IDT) and adjust care plan as needed. An incident report dated 11/13/21, at 7:00 a.m.	F 609	Immediate Corrective Action: A root cause analysis was completed to identify contributing factors which caused the break in facility policy and to aid in the implementation of interventions to prevent a recurrence. Corrective Action as it Applies to Others: The Abuse prevention policy and procedure was reviewed and remains current. The IDT and facility staff will be educated on the Abuse Prevention Policy regarding reporting of alleged violations. Prevent Recurrence: Incidents will be reported in accordance with facility policy for abuse prevention. During daily clinical meeting, incidents will be reviewed by the IDT to ensure reporting requirements have been met based on the nature of the alleged violation. Date Certain: April 8, 2022 Ongoing Monitoring: Incident report audits will be completed to	

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F 609	Continued From page 6 indicated R20 had sustained a bruise which was reported to registered nurse (RN)-A during shift report from night shift. The bruise was located on R20's left temple and measured seven by nine centimeters in size. R20 had stated he did not know he had a bruise. It was unknown how the bruise occurred. The incident report indicated the director of nursing (DON), the administrator and R20's physician had been notified of the injury. R20's progress note dated 11/13/21, identified a seven by nine centimeter bruise was located on R20's left temple. R20 was unable to report what had happened. R20's progress notes lacked any further documentation related to the bruise. During joint interview with the director of nursing (DON) and the assistant director of nursing (ADON) on 3/9/22, at 1:26 p.m. the ADON stated resident falls and bruises were documented and any changes would be discussed in the daily IDT meetings. The IDT would try to determine the the cause of the injury and if able, it would be documented in the resident's progress notes the probable cause and the solution. She did remember R20 had sustained a bruise to his left temple and had thought it was odd. They had thought maybe he had drooped his head and hit it against the side of his wheelchair. The ADON indicated R20's bruise was a reportable incident to the SA and a report should have been filed; but was not. The DON indicated he was unable to find any further follow up with the incident in R20's medical record. When interviewed on 3/10/22, at 1:58 p.m. the administrator stated he remembered they had discussed R20's bruise during an IDT meeting. It was proposed the injury may have been caused	F 609	ensure alleged violations were reported in accordance with facility policy and procedures for abuse prevention. 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 further recommendations. Monitored By: Executive Director or designee	

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	245138	A. BUILDING _____ B. WING _____	C 03/10/2022

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F 609	Continued From page 7 by the side panel on his high backed wheel chair or possibly could have been from the mechanical lift during a transfer. The administrator indicated an investigation was done through risk management when a bruise or fall occurred and they would address those through the IDT process. They did not record minutes for the IDT meetings, so nothing was documented related to R20's bruise investigation. The facility's practice was to report injuries to the SA when they cold not determine the cause, if it was a major injury or in a suspicious area. The administrator indicated R20's bruise was not reported because it was thought to have occurred by his wheel chair side panel or the mechanical lift during a transfer. The facility policy Freedom From Abuse, Neglect, and Exploitation, dated May 2020, defined an injury of unknown source when it was not observed by any person, the injury could not be explained by the resident and the injury was suspicious because of the extent of the injury or the location of the injury. The policy indicated incidents of possible abuse or neglect, such as suspicious bruising of residents would be identified and the administrator, DON or designee would notify the appropriate regulatory, investigative, or law enforcement agencies in accordance with state regulations.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		4/8/22

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F 610	Continued From page 8 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate bruising of unknown origin for 1 of 1 residents (R20) reviewed for abuse. Findings include: R20's quarterly Minimum Data Set (MDS) dated 1/22/22, indicated R20 had diagnoses that included Parkinson's disease, dementia, and diabetes. R20 had severe cognitive impairment and required extensive assistance to complete all activities of daily living (ADLs). R20's care plan with revision date of 11/29/21, indicated he required assistance of one to two staff with dressing, grooming, toileting, bed mobility and transfers. Staff were to use a mechanical stand with transfers. The care plan identified an individual abuse prevention plan due to R20 had moments of aggression, verbal and physical towards staff. Staff were to monitor for all injuries and discuss in IDT and adjust care plan as needed.	F 610	Immediate Corrective Action: A root cause analysis was completed to identify contributing factors which caused the break in facility policy and to aid in the implementation of interventions to prevent a recurrence. Corrective Action as it Applies to Others: The Abuse prevention policy and procedure was reviewed and remains current. The IDT and facility staff will be educated on the Abuse Prevention Policy regarding the investigation, prevention, and correction of alleged violations. Prevent Recurrence: Alleged violations will be investigated and documented in accordance with facility policy. Documentation of the alleged violation will be reviewed by the IDT and Date Certain: April 8, 2022 Ongoing Monitoring:	

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F 610	Continued From page 9 On 11/13/21, at 7:00 a.m. an incident report identified R20 had sustained a bruise which was reported to registered nurse (RN)-A during shift report from night shift. The bruise was located on R20's left temple and measured seven by nine centimeters in size. R20 had stated he did not know he had a bruise. It was unknown how the bruise occurred. The incident report indicated the director of nursing (DON), the administrator and R20's physician had been notified of the injury. R20's progress note dated 11/13/21, identified a seven by nine centimeter bruise was located on R20's left temple. R20 was unable to report what had happened. R20's progress notes lacked any further assessment related to the bruise. R20's medical record lacked documentation of investigation of his bruise of unknown origin. During joint interview with the director of nursing (DON) and the assistant director of nursing (ADON) on 3/9/22, at 1:26 p.m. the ADON stated resident falls and bruises were documented and if any changes, they would be discussed in the daily interdisciplinary team meetings (IDT). The IDT would try to determine the the cause of the injury and if able, it would be documented in the resident's progress notes the probable cause and the solution. She did remember R20 had sustained a bruise to his left temple and had thought it was odd. They had thought maybe he had drooped his head and hit it against the side of his wheelchair. The DON indicated they had "found" the cause of the injury to be from R20 bumping his head on the side of his wheel chair. The DON was unable to find record of any investigation, follow up with the incident or interviews with staff related to the incident.	F 610	Audits will be completed to ensure alleged violations are investigated and according to facility policy and procedures for abuse prevention. 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 further recommendations. Monitored By: DON or designee	

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F 610	Continued From page 10 When interviewed on 3/10/22, at 1:58 p.m. the administrator stated he remembered they had discussed R20's bruise during an IDT meeting. It was proposed the injury may have been caused by the side panel on his high backed wheel chair or possibly could have been from the mechanical lift during a transfer. The administrator confirmed there was no formal investigation of the incident and nothing had been documented. The administrator indicated an investigation would be done through risk management when a bruise or fall occurred and they would address those through the IDT process. They did not record minutes for the IDT meetings, so nothing was documented related to R20's bruise investigation. The facility policy Freedom From Abuse, Neglect, and Exploitation, dated May 2020, indicated incidents of possible abuse or neglect, such as suspicious bruising of residents would be identified. Allegations of abuse would be thoroughly investigated upon receipt of the allegation. The administrator or designee would complete the investigation process. Investigation could include but was not limited to the name of the resident involved, the date and time of the incident, the circumstances surrounding the incident, where the incident took place, names of any witnesses, and the person(s) alleged with committing the act.	F 610		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and	F 655		4/8/22

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F 655	Continued From page 11 implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.	F 655		

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F 655	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a baseline care plan to ensure immediate resident needs were identified and addressed for 2 of 3 residents (R231, R17) reviewed for comprehensive care planning and new admissions. Findings include: R231's admit tool indicated an admission date of 3/3/22, for chronic obstructive pulmonary disease (COPD). R231's electronic medical record (EMR) and paper chart lacked evidence of a baseline care plan. During an interview on 3/10/22, at 8:17 a.m. the assistant director of nursing (ADON) stated the baseline care plan was to be done upon admission and was important because it would direct the initial plan of care for R231. The ADON checked R231's EMR and paper chart and stated a baseline care plan was not done for R231 and should have been. R17's undated Admission Record indicated she was admitted to the facility on 1/4/22, with diagnoses including atrial fibrillation (irregular heart beat), hypertension, difficulty walking, kidney disease and enterocolitis due to clostridium difficile (C. Diff) (an infection in the large colon). R17's admission Minimum Data Set (MDS) dated 1/11/22, indicated she was cognitively intact and exhibited occasional behavior symptoms not	F 655	Immediate Corrective Action: Baseline care plans were developed for residents R231, and R17. Corrective Action as it Applies to Others: An audit will be completed to ensure each resident has a resident-centered baseline care plan or comprehensive care plan in place of the baseline care plan. Residents without a baseline or comprehensive care plan will have one developed based on the findings of the facility audit. Prevent Recurrence: The policy and procedure for developing baseline care plans was reviewed and remains current. Licensed nursing staff will be educated on the policy to ensure individualized resident centered care plans are developed within 48 hours of admission. Date Certain: April 8, 2022 Ongoing Monitoring: Audits will be completed following admission to ensure baseline care plans are completed in accordance with facility 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 A Summary of audit results will be reviewed during the monthly QAPI	

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F 655	Continued From page 13 directed toward others. R17 was frequently incontinent of bowel and bladder and required extensive assistance with all activities of daily living (ADLs). R17's medical record was reviewed and lacked any evidence a baseline care plan had been developed to ensure staff were knowledgeable in R17's care needs, despite R17 having a C. Diff infection and need for special infection control measures to prevent the spread of the infection to other residents and staff. During an interview on 3/10/22, at 10:25 a.m. the assistant director of nursing (ADON) reviewed R17's medical record and verified the lack of a baseline care plan. The ADON stated nursing should have completed the baseline care plan to ensure staff were instructed in R17's care needs and they would know how to care for her. The facility's Baseline Resident Centered Care Plan policy dated May 2020, identified all residents would have a baseline care plan that included the instruction needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan would be developed and implemented for each resident within 48 hours of admission.	F 655	meeting for the next 60 days for further recommendations. Monitored By: DON or designee	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		4/8/22

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F 656	Continued From page 14 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a person	F 656	Immediate Corrective Action: The person-centered comprehensive care	

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F 656	Continued From page 15 centered comprehensive plan of care identified and included interventions to assess and treat resident symptoms related to their diagnoses, potential for decline, addressed care needs and/or treatment for contractures (a permanent shortening of a muscle or joint) for 2 of 13 residents (R20, R10) reviewed for comprehensive care plans. Findings include: R20's undated Admission Record indicated R20 had diagnoses of Parkinson's disease, dementia, and diabetes. R20's quarterly Minimum Data Set (MDS) dated 1/22/22, indicated R20 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADLs). R20 had impaired range of motion (ROM) on one side on his upper extremities and did not ambulate. R20's ADL Care Area Assessment (CAA) dated 7/21/21, indicated R20 required extensive assistance with all ADLs. The CAA identified R20 was at risk for contractures as a complication of immobility. Continued staff assist with ADLs and mobility each shift would be care planned in order to avoid complications and referrals to others disciplines was not warranted. Existing contractures were not identified on the CAA. R20's care plan last revised 11/29/21, indicated R20 had Parkinson's disease and directed staff to encourage exercise and mobility. Staff were to report any improvement or decline to the physician. The care plan also identified R20 had limited physical mobility related to his Parkinson's disease and dementia. Staff were directed to	F 656	plan for R20 was reviewed and updated to include additional information regarding R20□s left hand contracture and palm protector. The person-centered comprehensive care plan for R10 was reviewed and updated to include information regarding R10□s edema, pain, pressure ulcer risk, and ADLS. Corrective Action as it Applies to Others: An audit will be completed to ensure comprehensive care plans are developed for other residents with limited ROM, pain, edema, pressure ulcer risk, and ADL dependency. Person centered care plans will be updated, as needed, audit to ensure care plans are comprehensive based on the facility audit. Prevent Recurrence: The policy and procedure for comprehensive care plans was reviewed and remains current. Licensed nursing staff will be educated on the policy. Date Certain: April 8, 2022 Ongoing Monitoring: Audits will be completed following admission to ensure baseline care plans are completed in accordance with facility 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	

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F 656	Continued From page 16 monitor and document signs and symptoms of immobility, contractures forming or worsening and skin breakdown. The care plan lacked identification R20 had a contracture to his left hand, as well as interventions of placing a palm guard in R20's left hand. In addition, the nursing assistant (NA) care sheet dated 1/3/22, lacked direction for use of a palm protector. On 3/9/22, at 3:37 p.m. and on 3/10/22, at 8:20 a.m. R20 was observed sitting in his wheel chair with a palm protector in place in his left hand. During interview on 3/10/22, at 10:15 a.m. occupational therapist aide (OTA)-A stated she was not aware R20 used a palm protector. It had not been initiated by Occupational Therapy and OTA-A felt it must have been a nursing intervention. She did not know when the palm protector had been implemented. When interviewed on 3/9/22, at 1:26 p.m. assistant director of nursing (ADON) stated they had implemented the sheepskin palm protector but was unsure when the intervention was initiated. During interview on 3/9/22, at 2:54 p.m. the director of nursing (DON) stated R20's care plan did not address interventions to treat R20's contracture to his left hand and the care plan and NA care sheets should have been updated to include the use of the palm protector. 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.	F 656	A Summary of audit results will be reviewed during the monthly QAPI meeting for the next 60 days for further recommendations. Monitored By: DON or designee	

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F 656	Continued From page 17	F 656		

R10's Admission Record printed 3/10/22, identified diagnoses that included Diabetes Mellitus, chronic diastolic heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), morbid obesity, lumbar spinal stenosis (a condition in which the spinal column narrows putting pressure on the nerves in the spinal column), carpal tunnel syndrome of the right upper extremity, and polyosteoarthritis (joint disease in at least five joints with inflammation, pain, restricted movement, and swelling).

R10's admission Minimum Data Set (MDS) dated 1/20/22, indicated R10 was cognitively intact, had adequate vision and hearing, required extensive assistance with ADLs, was frequently incontinent of bowel and bladder, was on scheduled pain medications in the past five days, and was at risk for developing pressure ulcers.

R10's Care Area Assessment (CAA) dated 1/20/22, triggered potential for ADL decline (physical immobility), urinary incontinence, falls, and pressure ulcer/injury. The analysis of findings indicated the facility would care plan in these areas.

R10's care plan initiated on 1/22/22, did not indicate potential concerns related to R10's chronic congestive heart failure and edema, his pain related to lumbar spinal stenosis, polyosteoarthritis, and carpal tunnel syndrome, his need for assistance with ADLs, or his potential for development of pressure ulcers.

The nursing assistant care guide undated, indicated R10 as incontinent of bowel and bladder.

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F 656	Continued From page 18 R10's Braden skin assessment (a tool to measure risk of skin impairment) dated 1/14/22, indicated R10 scored 16 (mild risk). The summary was as follows: at risk for skin breakdown. Can only make slight movements and incontinent of bladder. R10's physician progress note dated 2/28/22, at 9:40 a.m. indicated R10's only complaint was the chronic issues with the neuropathy in his hands and feet. Mild edema was noted in R10's extremities. On 3/7/22, at 3:21 p.m. R10 was seated in his recliner and stated he had pain in his hands. On 3/8/22, at 1:47 p.m. R10 was seated in his recliner and complained of his feet and hands hurting. On 3/10/22, at 1:13 p.m. the director of nursing (DON) stated R10's care plan lacked identification, goals, or interventions for edema, pain, pressure ulcers, and ADLs. The DON verified nursing was responsible for completing and ensuring the residents care plan was complete. The facility policy titled Care Plan - Reviews/Conferences revision date 5/2020, indicated the care plan review/conference would be quarterly and as needed and would provide an in-depth review of the resident's plan of care.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		4/8/22

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F 657	Continued From page 19 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a care plan was revised to address significant weight loss for 1 of 13 resdient's (R16) reviewed for care plans. Findings include: R16's Admission Record printed 3/10/22, identified R16's diagnoses included Alzheimer's disease, dementia, and depression.	F 657	Immediate Corrective Action: The care plan for R13 was updated to address the resident□s current nutritional status. Corrective Action as it Applies to Others: An audit will be completed to ensure nutrition care plans are current for each resident based on the resident□s individual needs. Other resident care plans will be updated,	

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F 657	Continued From page 20 R16's annual Minimum Data Set (MDS) dated 1/27/22, indicated R16 was severely cognitively impaired, required extensive assistance to dependence on activities of daily living (ADLs) and was dependent on others to eat. In addition, R16's MDS identified weight loss. R16's Care Area Assessment (CAA) dated 1/27/22, triggered nutritional status, and the need to have this care planned. The CAA indicated a referral was needed for a registered dietician. In addition, the CAA triggered dental care, edentulous, does not wear dentures and would have a trial of pureed food, to be care planned. R16's care plan initiated 11/6/20, revised 5/21/21, indicated R16 would have assistance with meals as needed, general diet, three meals per day and an evening snack. R16's care plan for nutrition/hydration initiated 6/15/21, indicated R16 would receive a regular diet, and to offer nutritional supplements with medication pass as willing to accept. The care plan indicated R16 would need to be fed. On 8/16/21, R16 weighed 100 pounds. On 2/28/22, R16 weighed 86 pounds, this was a 14% weight loss. A 1/20/22, 3:06 p.m. dietary note indicated R16 was tolerating a pureed diet and eating better without dentures but required more assistance from staff with eating. A 1/24/22, 11:00 a.m. progress note indicated a care conference was held with R16's son present. R16's son expressed concern over her continued weight loss.	F 657	as needed, based on the facility audit, to ensure nutrition care plans are completed accurately and reflect the resident□s current nutritional status. Prevent Recurrence: The policy and procedure for comprehensive care plans was reviewed and remains current. Licensed nursing staff will be educated on the policy. Date Certain: April 8, 2022 Ongoing Monitoring: Weekly audits will be completed to ensure residents have nutrition care plans based on the resident□s individual needs. 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 further recommendations. Monitored By: DON or designee	

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A 2/17/22, 2:14 p.m. dietary note indicated R16 had a slow continuous weight loss. On 7/12/21, R16 weighed 99.4 pounds. On 2/14/21, R16's weight was 85.4 pounds. The dietary note indicated she was tolerating a pureed diet.

R16's physician orders dated after 3/10/22, indicated R16's ordered diet was a mechanical soft diet. In addition, four ounces of Boost or house supplement three times a day and to document the percent taken.

On 3/9/22, at 7:07 a.m. R16 was observed lying in bed on her left side.
On 3/9/22, at 8:10 a.m. the breakfast trays arrived on the unit.
On 3/9/22, at 8:22 a.m. R16's roommate received her breakfast tray.
On 3/9/22, at 9:09 a.m. after staff performed morning cares R16 refused to get up out of bed.
On 3/9/22, at 9:19 a.m. nursing assistant (NA)-A sat at R16's bedside and fed her breakfast, which was a mechanical soft as ordered.
On 3/9/22, at 9:31 a.m. dietary aide (DA)-A stated R16 had eaten 60% of her breakfast.
On 3/9/22, at 12:19 p.m. R16 was seated alone in the dining room at a table.
On 3/9/22, at 12:36 p.m R16 was fed by NA-A she ate approximately 50% of her meal and then started spitting food out. NA-A stopped helping R16 eat at that point.

On 3/10/22, at 8:35 a.m. R16 remained in bed she was fed by NA-B. R16 ate 100% of her breakfast.

On 3/10/22, at 1:05 p.m. the director of nursing (DON) verified R16's care plan was not updated and revised after the dietician saw her on

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F 657	Continued From page 22 2/14/22, and noted a continued weight loss. The DON confirmed R16's current care plan conflicted with her current physician orders. The care plan had her diet as general and the physician orders were for a mechanical soft diet. The DON verified no one had updated R16's care plan after her most recent care conference on 1/24/22. The DON verified nursing was responsible for ensuring care plans are updated and kept current. The facility policy titled Care Plan - Reviews/Conferences revision dated 5/2020, indicated the care plan review/conference would be quarterly and as needed and would provide an in-depth review of the resident's plan of care.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	F 688		4/8/22

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F 688	Continued From page 23 by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services for 1 of 3 residents (R20) who had identified ROM limitations in his left fingers and thumb and had sustained a potential decrease in ROM. Finding include: R20's annual Minimum Data Set (MDS) dated 7/26/21, indicated R20 had diagnoses that included Parkinson's disease, dementia, and diabetes. R20 required extensive assistance to total assist with all areas of daily living (ADLs) and mobility. R20 had no ROM impairments to his upper extremities and had impairments to his ROM of both lower extremities. R20's quarterly MDS dated 10/22/21, indicated R20 had diagnoses that included Parkinson's disease, dementia, and diabetes. R20 had severe cognitive impairment and required extensive assistance with all areas of ADLs and mobility. R20's ROM was not assessed for impairments on either the upper or lower extremities. R20's quarterly Minimum Data Set (MDS) dated 1/22/22, indicated R20 had diagnoses that included Parkinson's disease, dementia and diabetes. R20 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADLs) and mobility. R20 had impaired ROM on one side in his upper extremities and ambulation did not occur. R20's activities of daily living Care Area Assessment (CAA) dated 7/26/21, indicated he required extensive assistance of one to two	F 688	Immediate Corrective Action: Resident R20 was reassessed, and orders were obtained for Occupational Therapy to evaluate and treat. The facility employs a COTA and PTA and these individuals will be utilized to conduct ROM activities with residents upon referral. Corrective Action as it Applies to Others: An audit will be completed to ensure other residents who have or are at risk for limited ROM or mobility are receiving nursing services to improve or prevent a decrease in ROM or mobility. Interventions will be implemented to ensure any identified residents are receiving appropriate nursing services based on the facility audit. Prevent Recurrence: The policy and procedure for restorative nursing services was reviewed and remains current. Licensed nursing staff will be educated on the policy. Date Certain: April 8, 2022 Ongoing Monitoring: Weekly audits will be completed to ensure residents with limited ROM or mobility are receiving nursing services prevent a decline in functional status. Audits will be completed as follows: - 5 times per week X 2 weeks - 2 times per week X 2 weeks - Weekly X 4 weeks	

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F 688	Continued From page 24 people and use of the mechanical stand lift to transfer and was non-ambulatory. R20's functional status was to be addressed in the care plan to avoid complications. The CAA lacked identification of any contractures with R20's extremities. R20's Pain Assessment Screening Tool dated 1/21/22, indicated R20 did not complain of pain. R20's Occupational Therapy (OT) Discharge Summary dated 8/28/20, indicated R20 was being discharged from OT services, but would remain residing in the facility. His prognosis was excellent to maintain his current level of function with consistent staff support. Discharge recommendations were to continue daily engagement in bilateral upper extremity strengthening and ROM for support of functional use of the upper extremities in activities of daily living. Review of OT notes from start of services 7/30/20, to discharge from services 8/28/20, lacked identification of any contractures or concerns related to R20's left hand. R20's Physical Therapy (PT) Discharge Summary dated 8/28/20, indicated R20 was able to ambulate a few feet with moderate assistance in the parallel bars. R20's prognosis to maintain his current level of function was good with consistent staff follow through. Discharge recommendations were for R20 to continue his home exercise plan and sitting at the edge of the bed for core strength. Review of PT notes from initiation of services 7/28/20, to discharge from services 8/28/20, lacked identification of any contractures or concerns related to R20's left hand. R20's care plan dated 11/29/21, indicated R20	F 688	A Summary of audit results will be reviewed during the monthly QAPI meeting for the next 60 days for further recommendations. Monitored By: DON/Designee	

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F 688	Continued From page 25	F 688		

had Parkinson's disease and directed staff to encourage exercises and to monitor for ability to perform ADLs and report any improvement or decline to the physician. Staff were to monitor for symptoms of Parkinson's complications which included poor balance, poor coordination, muscle cramps or rigidity, and decline in ROM. The care plan identified R20 had limited physical mobility related to his Parkinson's disease and dementia. Staff were directed to monitor and document signs and symptoms of immobility, contractures forming or worsening and skin breakdown. R20's care plan lacked identification of his left hand contracture, as well as interventions such as palm guard to this left hand.

R20's progress notes from 11/13/21, to 3/8/22 were reviewed, which lacked identification of R20's contracted (A permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff. This prevents normal movement of a joint or other body part) left hand. A progress note dated 2/18/22, was the first indication of R20 showing symptoms of pain and discomfort to left hand contracture. This progress note also indicated R20 began to resist his palm guard placement in his left hand. There was no indication in R20's progress notes, orders, care plan or aide care sheets regarding initiation or use of the palm guard.

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, there no documentation in notes, care plan or aide sheet related to use of a palm guard.

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F 688	Continued From page 26	F 688		

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.

On 3/7/22, at 3:28 p.m. R20 was observed sitting in a reclined position in a recliner in his room. His left hand was resting palm down on his lap. The left hand was tightly contracted in a fist position with his pointer finger rigidly fully extended. The remaining three fingers were tightly closed and nails were pressed into the palm of his hand with his thumb curled tightly over the fingers. R20 was unable to turn his hand independently to have the palm face up. He stated his hand hurt. There was no positioning devices in place for his left hand or left arm and no devices were visible in the room.

On 3/10/22, at 8:20 a.m. R20 was observed sitting in the dining room eating breakfast. He had a soft palm guard placed in his left hand. He was unable to turn his hand to face upward and the fingers of his left hand appeared tightly contracted and stiff. R20 stated his left hand hurt and was worse when touched.

During interview on 3/9/22, at 2:51 p.m. nursing assistant (NA)-A stated R20's left hand had been contracted but it had recently gotten worse. R20 would become more agitated when they tried to move or even touch his left hand and he resisted the palm guard. NA-A indicated you could really tell it bothered R20 more than it had before. NA-A stated nursing did not do ROM exercises with residents. Exercises were done by therapy.

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F 688	Continued From page 27	F 688		

During joint interview with the director of nursing (DON) and the assistant director of nursing (ADON) on 3/9/22, at 1:26 p.m. the ADON stated the facility staff did not do ROM with residents. They did not have a ROM program for any of their residents and they should be talking more with therapy regarding ROM exercise. The ROM assessments for the MDS's were not being done as she had been trying to figure out a way for them to be completed. A ROM assessment had not been done on R20 since before July 2021, and the ADON was unsure when the last ROM assessment had been completed for R20. The DON stated R20's contracture to his left hand was not identified on his care plan and the problem with interventions should have been identified.

During interview on 3/10/22, at 10:15 a.m. occupational therapist aide (OTA)-A indicated she assisted residents with their OT exercises after the therapist had completed the screening and setup the program. She had worked with R20 7/30/20, through 8/28/20, when he was first admitted to the facility. His hand was a little tight, but she was never made aware R20 had a contracture and OT had not implemented the palm guard for his hand. OTA-A stated nursing must have implemented the palm guard as she was not aware R20 was having any issues with his hands. If R20 was having pain in his hand, she would have thought nursing would have involved OT. OTA-A indicated sometimes gentle massage, warm soaks and other interventions may have helped and could have possibly avoided a surgical evaluation.

On 3/10/22, at 10:15 a.m. OTA-A was observed

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F 688	Continued From page 28 attempting to open R20's fingers to his left hand. R20 immediately began to complain of pain and grimace. R20 was unable to straighten his left arm in full extension and was unable to rotate left hand to face palm up. OTA-A indicated R20's fingers on his left hand were very tight and she was unable to get them open enough to assess the skin of his left palm. OTA-A indicated he would have had to have more movement in his left hand in order to use the parallel bars as was documented in R20's therapy notes from July 2020 through August 2020. R20 would not have been able to grasp the parallel bars currently as his left hand was to contracted now. R20 stated his hand had started hurting him more in recent weeks. The facility policy Restorative Program dated May 2020, indicated all residents were supported to maintain or attain their highest level of functioning. All residents would be assessed at admission and at each care plan meeting for possible inclusion in restorative programs. Restorative programs included incontinence management, ROM, splint or brace use, and training and skill practice in ADLs. The facility policy Rehabilitation Service Orders dated May 2020, indicated the facility would provide physical, occupational and speech therapy to attain or maintain function and/or prevent decline with a physician ordered treatment plan.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692		4/8/22

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F 692	Continued From page 29 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This 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: R17's significant change Minimum Data Set (MDS) 1/28/22, identified R17 had diagnoses including atrial fibrillation (irregular heart beat), hypertension, kidney disease, Barretts esophagus (the lower portion of the colon thick and inflamed due to acid reflux disease), and entercolitis due to clostridium difficile. R17 had intact cognition and required supervision with eating. R17's height	F 692	Immediate Corrective Action: Resident R17 was reassessed for weight loss and interventions were implemented to reduce or prevent continued weight loss. An order for a nutritional supplement was obtained, the culinary director meets with R17 daily to determine food likes and dislikes and intakes are now monitored. Corrective Action as it Applies to Others: An audit of residents who have had a noted weight loss without current interventions to prevent or reduce continued weight loss will be completed. Interventions to reduce or prevent weight loss will be implemented based on audit findings.	

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F 692	Continued From page 30 was recorded as 64 inches and her weight was recorded at 160 pounds. The MDS did not identify a weight gain or loss had occurred. R17's Physician Orders dated 3/10/22, indicated R17 was to receive a no added salt, mechanical soft texture diet. R17's Care Plan with print date 3/10/22, lacked a nutritional or dietary focus and no interventions were documented. R17's Nutritional Care Area Assessment (CAA) dated 2/8/22, indicated R17 ate her meals in her room and was a "picky eater". She had been experiencing some nausea and pain and requested small meals. She identified having problems chewing meat at times. Meal consumption was to be monitored daily and weights weekly. A referral to a registered dietician was indicated for a full assessment. On 1/20/22, a dietary progress note indicated R17's status was reviewed. Her initial weight of 163 pounds (lbs) on 1/4/22, was down "a bit" to 159 lbs. Another weight was recommended to ensure no further weight loss. R17's intake at meals was 50-100 percent. On 2/17/22, a dietary progress note indicated R17 continued to have a weight loss and her weight was now down to 131 lbs. Another weight was recommended as well as supplements two times per day. Staff were to encourage meal intakes and the dietician would add R17 to her monthly reviews. R17's Search Vitals Results listing dated from admission 1/4/22, to 3/7/22, identified the	F 692	Prevent Recurrence: The policy and procedure for weight loss was reviewed and remains current. Licensed nursing staff will be educated on the policy. Date Certain: April 8, 2022 Ongoing Monitoring: Weekly audits will be completed to ensure appropriate interventions are implemented to reduce or prevent weight loss based on the resident□s individual needs. 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 further recommendations. Monitored By: DON or designee	

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	245138	A. BUILDING _____ B. WING _____	C 03/10/2022

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F 692	Continued From page 31	F 692		

following recorded weights for R17:

- On 1/4/22, R17 weighed 162 lbs;

- On 1/7/22, R17 weighed 159 lbs;

- On 2/17/22, R17 weighed 141 lbs, and

-On 3/7/22, R17 weighed 144 lbs. (an 18 lb. weight loss in 60 days).

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.

During joint interview with licensed practical nurse (LPN)-A and LPN-C on 3/10/22, at 9:43 am. LPN-A stated the nurses entered the weekly bath weights into the chart. If a weight discrepancy occurred, the system would flag and warn them. They would then notify the dietary manager (DM)-A. The program would flag a 5% or greater weight loss or gain from the previous weeks

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F 692	Continued From page 32	F 692		

weight, otherwise it would not flag. DM-A would inform nursing of the need for supplements. Nursing would get an order and schedule the supplements on the medication administration record (MAR). LPN-C indicated she was made aware R17 had a weight loss and she had verbally notified the director of nursing (DON) of the loss in weight. She had left it with the DON to do any needed follow up on it.

When interviewed on 3/10/22, at 10:01 a.m. DM-A stated the dietician came monthly, but they could always contact her by phone if needed. DM-A was aware of R17's weight loss and had been visiting with her and adding extra food to her trays that she knew R17 liked. R17 had made complaints of nausea and feeling like she was going to have an emesis. R17 had gained two pounds back last week and DM-A was confident things were improving. 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.

During interview on 3/10/22, at 9:55 a.m. the DON stated he had heard about R17's weight loss and it should have been discussed at the daily interdisciplinary team meeting (IDT). They would typically review any residents with weight loss at IDT meetings and discuss if a supplement should be added, however, nothing had been done regarding R17's loss of weight. R17's supplements should have been ordered as recommended by the dietician and R17's physician should have been notified of the resident's weight loss. Typically when staff notified him of a residents weight loss, he would

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F 692	Continued From page 33 discuss it with DM-A and notify the physician. The facility policy Weight Loss with review date May 2020, indicated the facility would ensure residents who entered the facility would not fall below their ideal body weight range, unless it was viewed as unavoidable. Residents identified as at risk for weight loss would be noted on their care plan with individualized interventions. Dietary consults would be completed and suggestions implemented. Dietary or designee and nurse's notes would address weight loss issues.	F 692		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to obtain physicians orders/guidance for 1 of 2 residents (R17) who had sustained a	F 710	Immediate Corrective Action: A physician□s order was obtained for R17 to receive nutritional supplements.	4/8/22

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F 710	Continued From page 34 significant weight loss and recommendations for twice a day supplements. In addition, the facility failed to obtain physician orders/guidance for 1 of 2 resident (R282) who had orders for physical therapy five times weekly and who would not be receiving therapy services as ordered. Findings include: R17's significant change Minimum Data Set (MDS) 1/28/22, identified R17 had diagnoses including atrial fibrillation (irregular heart beat), hypertension, kidney disease, Barretts esophagus (the lower portion of the colon thick and inflamed due to acid reflux disease), and entercolitis due to clostridium difficile. R17 had intact cognition and required supervision with eating. R17's height was recorded as 64 inches and her weight was recorded at 160 pounds. R17's Physician Orders dated 3/10/22, indicated R17 was to receive a no added salt, mechanical soft texture diet. R17's Care Plan with print date 3/10/22, lacked a nutritional or dietary focus and no interventions were documented. R17's Nutritional Care Area Assessment (CAA) dated 2/8/22, indicated R17 ate her meals in her room and was a "picky eater". She had been experiencing some nausea and pain and requested small meals. She identified having problems chewing meat at times. Meal consumption was to be monitored daily and weights weekly. A referral to a registered dietician was indicated for a full assessment. On 1/20/22, a dietary progress note indicated	F 710	The physician□s was updated that resident R282 did not receive therapy as ordered. Resident R282 is now receiving therapy as ordered. Corrective Action as it Applies to Others: An audit will be completed to ensure other residents with dietary recommendations for nutritional supplements have physician□s orders to receive supplements per dietary recommendations. An audit will be completed to ensure other residents with physical therapy orders have orders in accordance with therapy recommendations. Prevent Recurrence: The policy and procedure for Physician/Family Notification was reviewed and remains current. Licensed nursing staff will be educated on the policy. Date Certain: April 8, 2022 Ongoing Monitoring: Weekly audits will be completed to ensure dietary and therapy recommendations are communicated to the physician. 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 further recommendations.	

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F 710	Continued From page 35 R17's status was reviewed. Her initial weight of 163 pounds (lbs) on 1/4/22, was down a bit to 159 lbs. Another weight was recommended to ensure no further weight loss. R17's intake at meals was 50-100 percent. On 2/17/22, a dietary progress note indicated R17 continued to have a weight loss and her weight was now down to 131 lbs. Another weight was recommended as well as supplements two times per day. Staff were to encourage meal intakes and the dietician would add R17 to her monthly reviews. R17's Search Vitals Results listing dated from admission 1/4/22, to 3/7/22, identified the following recorded weights for R17: - On 1/4/22, R17 weighed 162 lbs. - On 1/7/22, R17 weighed 159 lbs, - On 2/17/22, R17 weighed 141 lbs, and -On 3/7/22, R17 weighed 144 lbs. (an 18 lb. weight loss in 60 days). 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. During interview on 3/10/22, at 9:43 a.m. licensed practical nurse (LPN)-C indicated she was made	F 710	Monitored By: DON or designee	

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F 710	Continued From page 36	F 710		

aware R17 had a weight loss and she had verbally notified the director of nursing (DON) of the loss in weight. She had left it with the DON to do any needed follow 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.

During interview on 3/10/22, at 9:55 a.m. the DON stated he had heard about R17's weight loss and it should have been discussed at the daily interdisciplinary team meeting (IDT). They would typically review any residents with weight loss at IDT meetings and discuss if a supplement should be added, however, nothing had been done regarding R17's loss of weight. R17's supplements should have been ordered as recommended by the dietician and R17's physician should have been notified of the resident's weight loss. Typically when staff notified him of a residents weight loss, he would discuss it with DM-A and notify the physician.

The facility policy Weight Loss with review date May 2020, indicated the facility would ensure residents who entered the facility would not fall below their ideal body weight range, unless it was viewed as unavoidable. Residents identified as at risk for weight loss would be noted on their care plan with individualized interventions. Dietary consults would be completed and suggestions implemented. Dietary or designee and nurse's notes would address weight loss issues. The physician would be made aware of at risk

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F 710	Continued From page 37	F 710		

residents with documentation in the medical record.

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 Daily Living (ADLs) Care Area Assessment (CAA) dated 3/4/22, identified R282 required assistance with his ADLs and mobility due to a recent right ankle fracture and he was non weight bearing to his right leg. R282 was at risk for falls. PT and OT services were ordered for strengthening, retraining and safety awareness.

R282's PT Evaluation and Treatment Plan dated 2/25/22, identified R282 would be seen for therapeutic exercises, neuromuscular reeducation, gait training therapy, and therapeutic activities five times per week for thirty days.

R282's PT visit notes from 2/25/22, through 3/9/22, were reviewed and identified PT services were provided 2/25/22, 2/28/22, 3/1/22, 3/2/22, 3/3/22 and 3/7/22. No therapy visit had been completed on 3/4/22, 3/8/22, and 3/9/22.

When interviewed on 3/7/22, at 3:46 p.m. R282 stated he was not receiving therapy as often as

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F 710	Continued From page 38 was ordered and he was in his bed most of the time. During interview on 3/10/22, at 8:29 a.m. occupational therapy aide (OTA)-A stated the facility usually has physical therapy daily Monday through Friday but the physical therapy aide (PTA)-A was off for two weeks. OTA-A stated the physical therapist would be coming to the facility two times per week and would do PTA-A scheduled exercises with the residents on those days. During interview on 3/10/22, at 2:54 p.m. the director of nursing (DON) stated if therapy was not making visits with a resident as ordered they would need to notify the primary physician of the missed visits and obtain new orders. He was aware the PTA-A was not working for 2 weeks and he would notify R282's physician of the missed visits now. The facility policy Notification to Physician/Family?Resident Representative of Change in Resident Health Status with revision date November 2016, indicated the facility would notify the physician whenever there was a need to alter treatment significantly.	F 710		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a	F 825		4/8/22

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F 825	Continued From page 39 lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide physical therapy as ordered for 1 of 3 residents (R282) reviewed for therapy services. Findings include: 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 admission Minimum Data Set (MDS) dated 2/28/22, indicated R282 had intact cognition and did not exhibit behavioral symptoms. The MDS identified R282 required extensive assistance with his activities of daily living (ADLs) and did not ambulate.	F 825	Immediate Corrective Action: The physician was updated that resident R282 did not receive therapy as ordered. Resident R282 is now receiving therapy as ordered. Corrective Action as it Applies to Others: An audit will be completed to ensure other residents with physician's orders for physical therapy are receiving services in accordance with the prescribed physician's order. Prevent Recurrence: The policy and procedure for Restorative Services was reviewed and remains current. Licensed nursing staff will be educated on the policy. Date Certain: April 8, 2022 Ongoing Monitoring: Weekly audits will be completed to ensure	

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F 825	Continued From page 40 R282's ADL Care Area Assessment (CAA) dated 3/4/22, identified R282 required assistance with his ADLs and mobility due to a recent right ankle fracture and he was non weight bearing to his right leg. R282 was at risk for falls. PT and OT services were ordered for strengthening, retraining and safety awareness. R282's PT Evaluation and Treatment Plan dated 2/25/22, identified R282 would be seen for therapeutic exercises, neuromuscular reeducation, gait training therapy, and therapeutic activities 5 times per week for thirty days. R282's PT visit notes from 2/25/22 through 3/9/22, were reviewed and identified PT services were provided 2/25/22, 2/28/22, 3/1/22, 3/2/22, 3/3/22 and 3/7/22. No therapy visit had been completed on 3/4/22, 3/8/22, and 3/9/22. When interviewed on 3/7/22, at 3:46 p.m. R282 stated he was not receiving therapy as often as was ordered and he was in his bed most of the time. During interview on 3/10/22, at 8:29 a.m. occupational therapy aide (OTA)-A stated the facility usually has physical therapy daily Monday through Friday but the physical therapy aide (PTA)-A was off for two weeks. OTA-A stated the physical therapist would be coming to the facility 2 times per week and would do PTA-A scheduled exercises with the residents on those days. During interview on 3/10/22, at 2:54 p.m. the director of nursing (DON) stated if therapy was not making visits with a resident as ordered they would need to notify the primary physician of the	F 825	therapy services are provided as prescribed by the resident□s physician. 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 further recommendations. Monitored By: DON or designee	

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F 825	Continued From page 41 missed visits and obtain new orders. He was aware the PTA-A was not working for two weeks as she was on vacation and he would notify R282's physician of the missed visits now. The facility policy Restorative Services Orders with revision date May 2020, indicated the facility would provide physical, occupational or speech therapy to attain or maintain function and/or prevent decline with a physician ordered treatment plan. The facility would obtain physician orders for rehabilitation services with specific discipline, treatment and duration.	F 825		
F 886 SS=L	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this	F 886		4/8/22

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paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.
This REQUIREMENT is not met as evidenced by:

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	245138	A. BUILDING _____ B. WING _____	C 03/10/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 43 Based on interview and document review, the facility failed to ensure staff who had symptoms of COVID-19 and had negative antigen test(s) were not allowed to work, and tested with a confirmatory real-time reverse transcription polymerase chain reaction (RT-PCR) test, according to CDC guidance. This deficient practice resulted in an immediate jeopardy (IJ) situation which had the high likelihood to cause serious illness and/or death to all 32 residents residing in the facility, along with staff and visitors. The IJ began on 1/10/22, when licensed practical nurse (LPN)-A reported COVID-19 symptoms and was allowed to work four shifts. The facility only conducted antigen testing, no NAAT or PCR testing to follow up, as is indicated in CDC guidance. On 1/18/22, her fifth shift, LPN-A tested positive with an antigen test. The administrator, director of nursing (DON), and assistant director of nursing/infection preventionist (ADON) were notified of the IJ on 3/8/22, at 3:48 p.m. The immediate jeopardy was removed on 3/9/22, at 12:29 p.m. when the facility implemented interventions to ensure all staff would be tested according to CDC guidelines; however, noncompliance remained at the lower scope and severity level of F, widespread, which indicated no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: The CDC guidance People with Certain Medical Conditions dated 5/13/21, identified older adults were more likely to get seriously ill from COVID-19. More than 80 percent of COVID-19 deaths have occurred in people over the age of 65, and more than 95 percent of COVID-19	F 886	Immediate Corrective Action: Covid-19 testing was immediately implemented in accordance with CDC recommendations including confirmatory testing for asymptomatic antigen positive residents and staff and staff performing confirmatory testing on symptomatic antigen negative residents and staff. Corrective Action as it Applies to Others: An audit was conducted to identify other residents and staff with symptoms of COVID-19 infection. Identified staff were immediately removed from work and RT-PCR testing was performed in accordance with CMS guidance and CDC recommendations. Prevent Recurrence: The policy and procedure for COVID-19 Testing of Residents and Staff was reviewed and revised to conform to current standards of practice for testing residents and staff for COVID-19. All staff were educated on the policy revisions on 3/8/2022. Ongoing Monitoring: Weekly audits will be completed to ensure continued compliance with CDC and CMS recommendations for COVID-19 testing for 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 reviewed during the monthly QAPI	

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F 886	Continued From page 44 deaths have occurred in people older than 45. Further, among adults, the risk for severe illness from COVID-19 increases with age, with older adults at highest risk. Severe illness means that the person with COVID-19 may require hospitalization, intensive care, or a ventilator to help them breathe, or they may even die. STAFF TESTING: The Centers for Disease Control and Prevention (CDC) guidance SARS CoV-2 Antigen Testing in Long Term Care Facilities dated 1/7/21, identified symptomatic people who test antigen negative should have a confirmatory test performed. Confirmatory test should be performed with nucleic acid amplifications tests (NAAT) such as reverse transcriptase polymerase chain reaction (RT-PCR). As the sensitivity of antigen tests is generally lower than RT-PCR, negative POC antigen tests should be considered presumptive. Testing of symptomatic residents or healthcare personnel (HCP). -If an antigen test is presumptive negative, perform NAAT immediately (e.g., within 2 days). -Symptomatic residents should be kept on transmission-based precautions until NAAT results return. -If a confirmatory NAAT is performed within 2 days, people should be assumed to be infectious until the confirmatory test results are completed. For instance, in general, if a symptomatic resident tests presumptive negative by antigen test and a NAAT is performed, the resident should remain in Transmission-Based Precautions until the NAAT result is available. The facility's Employee Tracking Tool 2022, indicated licensed practical nurse (LPN)-A	F 886	meeting for the next 60 days for further recommendations. Monitored By: DON or designee	

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F 886	Continued From page 45	F 886		

reported symptoms of cough, myalgia, and body aches on 1/10/22. The employee tracking tool indicated LPN-A repeatedly tested negative for COVID-19 each day of the four days she worked using an antigen test for COVID-19. However, the facility failed to test with a confirmatory RT-PCR test. LPN-A tested positive for COVID-19 with a facility antigen test on 1/18/22, the fifth day she was to work. LPN-A was then removed from the schedule. No confirmatory RT-PCR was done.

The facility's updated employee schedule for January 3, 2022, through January 30, 2022, identified LPN-A worked 1/10/22, 1/11/22, 1/12/22, and 1/17/22, and before being removed from the schedule on 1/18/22, when she tested positive for COVID-19 with the facility's antigen test prior to starting her shift. LPN-A was removed from the schedule for a period of 10 day quarantine. No confirmatory RT-PCR test was done.

During interview on 3/7/22, at 4:34 p.m. the facility infection preventionist (IP) stated the county COVID-19 transmission rate was high. The facility tested their employees with antigen testing and if it was negative, the employees were allowed to work their shift. When an employee tested because of symptoms, the facility evaluated them on a case by case basis and if the antigen test was negative, they were allowed to work their shift. Employees with COVID-19 symptoms with a negative antigen tests were required to wear an N95 mask while working, however, employees, included LPN-A, were not fit tested for N95 masks until February 2022. The IP verified LPN-A had worked with symptoms of cough and nasal congestion for four days before she tested positive with an antigen test on

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F 886	Continued From page 46	F 886		

1/18/22. The IP stated she was not sure why the facility was not using RT-PCR tests for their testing, but did indicate the antigen tests were quick and easy. They were able to send employees to the clinic for a PCR test if it was needed. If employee symptoms were mild such as a runny nose or cough and the employee tested negative with an antigen test, the facility required them to wear an N95 mask and they were allowed to work. The IP stated she did not send the employees to the clinic for a confirmatory PCR test. If an employee tested positive and had symptoms of COVID-19 they were sent home. The IP stated the facility had always used the antigen tests long before she started in August 2021.

When interviewed on 3/8/22, at 8:46 a.m. the administrator stated the facility tested their employees and residents with antigen testing only. The facility did not confirm negative or positive tests with RT-PCR tests, however, they did encourage their staff to obtain an RT-PCR test when/if they were symptomatic for COVID-19. When employees reported symptoms of illness, the facility would test them with an antigen test and if negative and symptoms appeared mild, they would allow the employee to work. If symptoms were more severe, they would send the employee home. The facility did not perform confirmatory RT-PCR tests to confirm a negative antigen test, even if the employee was reporting symptoms of illness.

In an interview on 3/8/22 at 1:30 p.m. the IP stated they had outbreak testing beginning on 1/8/22. Review of the facility's outbreak testing spreadsheets confirmed the first COVID-19 positive staff (contract) and another facility staff

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F 886	Continued From page 47	F 886		

on 1/8/22. This was only 2 days before LPN-A reported her COVID-19 symptoms and continued to work. No residents were positive for COVID-19 at the time LPN-A had symptoms. Two residents had symptoms in January (onset 1/10/22 [not tested for COVID-19], and onset 1/24/22 [negative antigen test]). Three other residents tested positive for COVID-19 on 2/5/22.

The facility policy Infection Prevention and Control: COVID-19 Testing, with revision date February 4, 2022, indicated staff with symptoms or signs of COVID-19, regardless of vaccination status, would be tested immediately and were expected to be restricted from the facility pending the results of COVID-19 testing. If COVID-19 was confirmed or not, staff who had symptoms of COVID-19 should follow the facility policy for return to work. The policy lacked identification of what test the facility was to use for testing of staff and residents.

The IJ which began on 1/10/22, was removed on 3/9/22, at 12:29 p.m., when it could be verified through interview and document review the facility immediately implemented COVID-19 testing in accordance with CDC guidance including confirmatory testing for asymptomatic antigen positive residents and staff and performing confirmatory testing on symptomatic antigen negative residents and staff. In addition, the facility would follow recommended infection prevention and control precautions for residents and staff with symptoms of COVID-19 illness. The facility reviewed policies and revised to reflect protocols for testing of to ensure all staff and residents were tested for COVID-19 in a manner consistent with current standards of practice for testing for COVID-1. Education was

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F 886	Continued From page 48 provided to all employees on current and updated COVID-19 protocols for testing.	F 886		

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 only a suggestion 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.

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/7/22, through 3/10/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaint was found to be UNSUBSTANTIATED: H5138043C (MN65426, MN65547, MN65547). 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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.	2 000		

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2 000	Continued From 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a person centered comprehensive plan of care identified and included interventions to assess and treat resident symptoms related to their diagnoses, potential for decline, addressed care needs and/or treatment for contractures (a permanent shortening of a muscle or joint) for 2 of 13 residents (R20, R10) reviewed for comprehensive care plans. Findings include: R20's undated Admission Record indicated R20 had diagnoses of Parkinson's disease, dementia, and diabetes. R20's quarterly Minimum Data Set (MDS) dated	2 565	Corrected.	4/8/22

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1/22/22, indicated R20 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADLs). R20 had impaired range of motion (ROM) on one side on his upper extremities and did not ambulate.

R20's ADL Care Area Assessment (CAA) dated 7/21/21, indicated R20 required extensive assistance with all ADLs. The CAA identified R20 was at risk for contractures as a complication of immobility. Continued staff assist with ADLs and mobility each shift would be care planned in order to avoid complications and referrals to others disciplines was not warranted. Existing contractures were not identified on the CAA.

R20's care plan last revised 11/29/21, indicated R20 had Parkinson's disease and directed staff to encourage exercise and mobility. Staff were to report any improvement or decline to the physician. The care plan also identified R20 had limited physical mobility related to his Parkinson's disease and dementia. Staff were directed to monitor and document signs and symptoms of immobility, contractures forming or worsening and skin breakdown. The care plan lacked identification R20 had a contracture to his left hand, as well as interventions of placing a palm guard in R20's left hand. In addition, the nursing assistant (NA) care sheet dated 1/3/22, lacked direction for use of a palm protector.

On 3/9/22, at 3:37 p.m. and on 3/10/22, at 8:20 a.m. R20 was observed sitting in his wheel chair with a palm protector in place in his left hand.

During interview on 3/10/22, at 10:15 a.m. occupational therapist aide (OTA)-A stated she was not aware R20 used a palm protector. It had not been initiated by Occupational Therapy and

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2 565	Continued From page 4	2 565		

OTA-A felt it must have been a nursing intervention. She did not know when the palm protector had been implemented.

When interviewed on 3/9/22, at 1:26 p.m. assistant director of nursing (ADON) stated they had implemented the sheepskin palm protector but was unsure when the intervention was initiated.

During interview on 3/9/22, at 2:54 p.m. the director of nursing (DON) stated R20's care plan did not address interventions to treat R20's contracture to his left hand and the care plan and NA care sheets should have been updated to include the use of the palm protector.

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 Record printed 3/10/22, identified diagnoses that included Diabetes Mellitus, chronic diastolic heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), morbid obesity, lumbar spinal stenosis (a condition in which the spinal column narrows putting pressure on the nerves in the spinal column), carpal tunnel syndrome of the right upper extremity, and polyosteoarthritis (joint disease in at least five joints with inflammation, pain, restricted movement, and swelling).

R10's admission Minimum Data Set (MDS) dated 1/20/22, indicated R10 was cognitively intact, had adequate vision and hearing, required extensive assistance with ADLs, was frequently incontinent of bowel and bladder, was on scheduled pain

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medications in the past five days, and was at risk for developing pressure ulcers.

R10's Care Area Assessment (CAA) dated 1/20/22, triggered potential for ADL decline (physical immobility), urinary incontinence, falls, and pressure ulcer/injury. The analysis of findings indicated the facility would care plan in these areas.

R10's care plan initiated on 1/22/22, did not indicate potential concerns related to R10's chronic congestive heart failure and edema, his pain related to lumbar spinal stenosis, polyosteoarthritis, and carpal tunnel syndrome, his need for assistance with ADLs, or his potential for development of pressure ulcers.

The nursing assistant care guide undated, indicated R10 as incontinent of bowel and bladder.

R10's Braden skin assessment (a tool to measure risk of skin impairment) dated 1/14/22, indicated R10 scored 16 (mild risk). The summary was as follows: at risk for skin breakdown. Can only make slight movements and incontinent of bladder.

R10's physician progress note dated 2/28/22, at 9:40 a.m. indicated R10's only complaint was the chronic issues with the neuropathy in his hands and feet. Mild edema was noted in R10's extremities.

On 3/7/22, at 3:21 p.m. R10 was seated in his recliner and stated he had pain in his hands.

On 3/8/22, at 1:47 p.m. R10 was seated in his recliner and complained of his feet and hands

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2 565	Continued From page 6 hurting. On 3/10/22, at 1:13 p.m. the director of nursing (DON) stated R10's care plan lacked identification, goals, or interventions for edema, pain, pressure ulcers, and ADLs. The DON verified nursing was responsible for completing and ensuring the residents care plan was complete. The facility policy titled Care Plan - Reviews/Conferences revision date 5/2020, indicated the care plan review/conference would be quarterly and as needed and would provide an in-depth review of the resident's plan of care. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents have person centered comprehensive cae plans to include interventions to assess and treat resident symptoms related to their diagnoses. 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 (21) days.	2 565		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be	2 890		4/8/22

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2 890	Continued From page 7 implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services for 1 of 3 residents (R20) who had identified ROM limitations in his left fingers and thumb and had sustained a potential decrease in ROM. Finding include: R20's annual Minimum Data Set (MDS) dated 7/26/21, indicated R20 had diagnoses that included Parkinson's disease, dementia, and diabetes. R20 required extensive assistance to total assist with all areas of daily living (ADLs) and mobility. R20 had no ROM impairments to his upper extremities and had impairments to his ROM of both lower extremities. R20's quarterly MDS dated 10/22/21, indicated R20 had diagnoses that included Parkinson's disease, dementia, and diabetes. R20 had severe cognitive impairment and required extensive assistance with all areas of ADLs and mobility. R20's ROM was not assessed for impairments on	2 890	Corrected.	

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2 890	Continued From page 8 either the upper or lower extremities. R20's quarterly Minimum Data Set (MDS) dated 1/22/22, indicated R20 had diagnoses that included Parkinson's disease, dementia and diabetes. R20 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADLs) and mobility. R20 had impaired ROM on one side in his upper extremities and ambulation did not occur. R20's activities of daily living Care Area Assessment (CAA) dated 7/26/21, indicated he required extensive assistance of one to two people and use of the mechanical stand lift to transfer and was non-ambulatory. R20's functional status was to be addressed in the care plan to avoid complications. The CAA lacked identification of any contractures with R20's extremities. R20's Pain Assessment Screening Tool dated 1/21/22, indicated R20 did not complain of pain. R20's Occupational Therapy (OT) Discharge Summary dated 8/28/20, indicated R20 was being discharged from OT services, but would remain residing in the facility. His prognosis was excellent to maintain his current level of function with consistent staff support. Discharge recommendations were to continue daily engagement in bilateral upper extremity strengthening and ROM for support of functional use of the upper extremities in activities of daily living. Review of OT notes from start of services 7/30/20, to discharge from services 8/28/20, lacked identification of any contractures or concerns related to R20's left hand. R20's Physical Therapy (PT) Discharge Summary	2 890		

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2 890	Continued From page 9 dated 8/28/20, indicated R20 was able to ambulate a few feet with moderate assistance in the parallel bars. R20's prognosis to maintain his current level of function was good with consistent staff follow through. Discharge recommendations were for R20 to continue his home exercise plan and sitting at the edge of the bed for core strength. Review of PT notes from initiation of services 7/28/20, to discharge from services 8/28/20, lacked identification of any contractures or concerns related to R20's left hand. R20's care plan dated 11/29/21, indicated R20 had Parkinson's disease and directed staff to encourage exercises and to monitor for ability to perform ADLs and report any improvement or decline to the physician. Staff were to monitor for symptoms of Parkinson's complications which included poor balance, poor coordination, muscle cramps or rigidity, and decline in ROM. The care plan identified R20 had limited physical mobility related to his Parkinson's disease and dementia. Staff were directed to monitor and document signs and symptoms of immobility, contractures forming or worsening and skin breakdown. R20's care plan lacked identification of his left hand contracture, as well as interventions such as palm guard to this left hand. R20's progress notes from 11/13/21, to 3/8/22 were reviewed, which lacked identification of R20's contracted (A permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff. This prevents normal movement of a joint or other body part) left hand. A progress note dated 2/18/22, was the first indication of R20 showing symptoms of pain and discomfort to left hand contracture. This progress note also indicated R20 began to resist his palm guard placement in	2 890		

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2 890	Continued From page 10	2 890		

his left hand. There was no indication in R20's progress notes, orders, care plan or aide care sheets regarding initiation or use of the palm guard.

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, there no documentation in notes, care plan or 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.

On 3/7/22, at 3:28 p.m. R20 was observed sitting in a reclined position in a recliner in his room. His left hand was resting palm down on his lap. The left hand was tightly contracted in a fist position with his pointer finger rigidly fully extended. The remaining three fingers were tightly closed and nails were pressed into the palm of his hand with his thumb curled tightly over the fingers. R20 was unable to turn his hand independently to have the palm face up. He stated his hand hurt. There was no positioning devices in place for his left hand or left arm and no devices were visible in the room.

On 3/10/22, at 8:20 a.m. R20 was observed sitting in the dining room eating breakfast. He had a soft palm guard placed in his left hand. He was unable to turn his hand to face upward and the fingers of his left hand appeared tightly contracted and stiff. R20 stated his left hand hurt

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2 890	Continued From page 11 and was worse when touched. During interview on 3/9/22, at 2:51 p.m. nursing assistant (NA)-A stated R20's left hand had been contracted but it had recently gotten worse. R20 would become more agitated when they tried to move or even touch his left hand and he resisted the palm guard. NA-A indicated you could really tell it bothered R20 more than it had before. NA-A stated nursing did not do ROM exercises with residents. Exercises were done by therapy. During joint interview with the director of nursing (DON) and the assistant director of nursing (ADON) on 3/9/22, at 1:26 p.m. the ADON stated the facility staff did not do ROM with residents. They did not have a ROM program for any of their residents and they should be talking more with therapy regarding ROM exercise. The ROM assessments for the MDS's were not being done as she had been trying to figure out a way for them to be completed. A ROM assessment had not been done on R20 since before July 2021, and the ADON was unsure when the last ROM assessment had been completed for R20. The DON stated R20's contracture to his left hand was not identified on his care plan and the problem with interventions should have been identified. During interview on 3/10/22, at 10:15 a.m. occupational therapist aide (OTA)-A indicated she assisted residents with their OT exercises after the therapist had completed the screening and setup the program. She had worked with R20 7/30/20, through 8/28/20, when he was first admitted to the facility. His hand was a little tight, but she was never made aware R20 had a contracture and OT had not implemented the palm guard for his hand. OTA-A stated nursing	2 890		

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2 890	Continued From page 12	2 890		

must have implemented the palm guard as she was not aware R20 was having any issues with his hands. If R20 was having pain in his hand, she would have thought nursing would have involved OT. OTA-A indicated sometimes gentle massage, warm soaks and other interventions may have helped and could have possibly avoided a surgical evaluation.

On 3/10/22, at 10:15 a.m. OTA-A was observed attempting to open R20's fingers to his left hand. R20 immediately began to complain of pain and grimace. R20 was unable to straighten his left arm in full extension and was unable to rotate left hand to face palm up. OTA-A indicated R20's fingers on his left hand were very tight and she was unable to get them open enough to assess the skin of his left palm. OTA-A indicated he would have had to have more movement in his left hand in order to use the parallel bars as was documented in R20's therapy notes from July 2020 through August 2020. R20 would not have been able to grasp the parallel bars currently as his left hand was to contracted now. R20 stated his hand had started hurting him more in recent weeks.

The facility policy Restorative Program dated May 2020, indicated all residents were supported to maintain or attain their highest level of functioning. All residents would be assessed at admission and at each care plan meeting for possible inclusion in restorative programs. Restorative programs included incontinence management, ROM, splint or brace use, and training and skill practice in ADLs.

The facility policy Rehabilitation Service Orders dated May 2020, indicated the facility would

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2 890	Continued From page 13 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 (21) days.	2 890		
2 940	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. 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:	2 940	Corrected.	4/8/22

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2 940	Continued From page 14 R17's significant change Minimum Data Set (MDS) 1/28/22, identified R17 had diagnoses including atrial fibrillation (irregular heart beat), hypertension, kidney disease, Barretts esophagus (the lower portion of the colon thick and inflamed due to acid reflux disease), and entercolitis due to clostridium difficile. R17 had intact cognition and required supervision with eating. R17's height was recorded as 64 inches and her weight was recorded at 160 pounds. The MDS did not identify a weight gain or loss had occurred. R17's Physician Orders dated 3/10/22, indicated R17 was to receive a no added salt, mechanical soft texture diet. R17's Care Plan with print date 3/10/22, lacked a nutritional or dietary focus and no interventions were documented. R17's Nutritional Care Area Assessment (CAA) dated 2/8/22, indicated R17 ate her meals in her room and was a "picky eater". She had been experiencing some nausea and pain and requested small meals. She identified having problems chewing meat at times. Meal consumption was to be monitored daily and weights weekly. A referral to a registered dietician was indicated for a full assessment. On 1/20/22, a dietary progress note indicated R17's status was reviewed. Her initial weight of 163 pounds (lbs) on 1/4/22, was down "a bit" to 159 lbs. Another weight was recommended to ensure no further weight loss. R17's intake at meals was 50-100 percent. On 2/17/22, a dietary progress note indicated R17 continued to have a weight loss and her weight was now down to 131 lbs. Another weight was	2 940		

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2 940	Continued From page 15 recommended as well as supplements two times per day. Staff were to encourage meal intakes and the dietician would add R17 to her monthly reviews. R17's Search Vitals Results listing dated from admission 1/4/22, to 3/7/22, identified the following recorded weights for R17: - On 1/4/22, R17 weighed 162 lbs; - On 1/7/22, R17 weighed 159 lbs; - On 2/17/22, R17 weighed 141 lbs, and -On 3/7/22, R17 weighed 144 lbs. (an 18 lb. weight loss in 60 days). 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. During joint interview with licensed practical nurse (LPN)-A and LPN-C on 3/10/22, at 9:43 am.	2 940		

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2 940	Continued From page 16 LPN-A stated the nurses entered the weekly bath weights into the chart. If a weight discrepancy occurred, the system would flag and warn them. They would then notify the dietary manager (DM)-A. The program would flag a 5% or greater weight loss or gain from the previous weeks weight, otherwise it would not flag. DM-A would inform nursing of the need for supplements. Nursing would get an order and schedule the supplements on the medication administration record (MAR). LPN-C indicated she was made aware R17 had a weight loss and she had verbally notified the director of nursing (DON) of the loss in weight. She had left it with the DON to do any needed follow up on it. When interviewed on 3/10/22, at 10:01 a.m. DM-A stated the dietician came monthly, but they could always contact her by phone if needed. DM-A was aware of R17's weight loss and had been visiting with her and adding extra food to her trays that she knew R17 liked. R17 had made complaints of nausea and feeling like she was going to have an emesis. R17 had gained two pounds back last week and DM-A was confident things were improving. 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. During interview on 3/10/22, at 9:55 a.m. the DON stated he had heard about R17's weight loss and it should have been discussed at the daily interdisciplinary team meeting (IDT). They would typically review any residents with weight loss at IDT meetings and discuss if a supplement should be added, however, nothing had been done regarding R17's loss of weight. R17's	2 940		

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2 940	Continued From page 17 supplements should have been ordered as recommended by the dietician and R17's physician should have been notified of the resident's weight loss. Typically when staff notified him of a residents weight loss, he would discuss it with DM-A and notify the physician. The facility policy Weight Loss with review date May 2020, indicated the facility would ensure residents who entered the facility would not fall below their ideal body weight range, unless it was viewed as unavoidable. Residents identified as at risk for weight loss would be noted on their care plan with individualized interventions. Dietary consults would be completed and suggestions implemented. Dietary or designee and nurse's notes would address weight loss issues. 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 (21) days.	2 940		
21285	MN Rule 4658.0710 Subp. 2 Admission Orders and Physician Evaluations Subp. 2. Admission orders. A nursing home must have physician orders for a resident's admission and immediate care at the time of	21285		4/8/22

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21285	Continued From page 18 admission. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to obtain physicians orders/guidance for 1 of 2 residents (R17) who had sustained a significant weight loss and recommendations for twice a day supplements. In addition, the facility failed to obtain physician orders/guidance for 1 of 2 resident (R282) who had orders for physical therapy five times weekly and who would not be receiving therapy services as ordered. Findings include: R17's significant change Minimum Data Set (MDS) 1/28/22, identified R17 had diagnoses including atrial fibrillation (irregular heart beat), hypertension, kidney disease, Barretts esophagus (the lower portion of the colon thick and inflamed due to acid reflux disease), and entercolitis due to clostridium difficile. R17 had intact cognition and required supervision with eating. R17's height was recorded as 64 inches and her weight was recorded at 160 pounds. R17's Physician Orders dated 3/10/22, indicated R17 was to receive a no added salt, mechanical soft texture diet. R17's Care Plan with print date 3/10/22, lacked a nutritional or dietary focus and no interventions were documented. R17's Nutritional Care Area Assessment (CAA) dated 2/8/22, indicated R17 ate her meals in her room and was a "picky eater". She had been	21285	Corrected.	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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experiencing some nausea and pain and requested small meals. She identified having problems chewing meat at times. Meal consumption was to be monitored daily and weights weekly. A referral to a registered dietician was indicated for a full assessment.

On 1/20/22, a dietary progress note indicated R17's status was reviewed. Her initial weight of 163 pounds (lbs) on 1/4/22, was down a bit to 159 lbs. Another weight was recommended to ensure no further weight loss. R17's intake at meals was 50-100 percent.

On 2/17/22, a dietary progress note indicated R17 continued to have a weight loss and her weight was now down to 131 lbs. Another weight was recommended as well as supplements two times per day. Staff were to encourage meal intakes and the dietician would add R17 to her monthly reviews.

R17's Search Vitals Results listing dated from admission 1/4/22, to 3/7/22, identified the following recorded weights for R17:

- On 1/4/22, R17 weighed 162 lbs.

- On 1/7/22, R17 weighed 159 lbs,

- On 2/17/22, R17 weighed 141 lbs, and

-On 3/7/22, R17 weighed 144 lbs. (an 18 lb. weight loss in 60 days).

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

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prevent or slow the continued loss of weight. The recommended twice a day supplements had not been implemented as recommended by the dietician.

During interview on 3/10/22, at 9:43 a.m. licensed practical nurse (LPN)-C indicated she was made aware R17 had a weight loss and she had verbally notified the director of nursing (DON) of the loss in weight. She had left it with the DON to do any needed follow 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.

During interview on 3/10/22, at 9:55 a.m. the DON stated he had heard about R17's weight loss and it should have been discussed at the daily interdisciplinary team meeting (IDT). They would typically review any residents with weight loss at IDT meetings and discuss if a supplement should be added, however, nothing had been done regarding R17's loss of weight. R17's supplements should have been ordered as recommended by the dietician and R17's physician should have been notified of the resident's weight loss. Typically when staff notified him of a residents weight loss, he would discuss it with DM-A and notify the physician.

The facility policy Weight Loss with review date May 2020, indicated the facility would ensure residents who entered the facility would not fall below their ideal body weight range, unless it was viewed as unavoidable. Residents identified as at

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risk for weight loss would be noted on their care plan with individualized interventions. Dietary consults would be completed and suggestions implemented. Dietary or designee and nurse's notes would address weight loss issues. The physician would be made aware of at risk residents with documentation in the medical record.

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 Daily Living (ADLs) Care Area Assessment (CAA) dated 3/4/22, identified R282 required assistance with his ADLs and mobility due to a recent right ankle fracture and he was non weight bearing to his right leg. R282 was at risk for falls. PT and OT services were ordered for strengthening, retraining and safety awareness.

R282's PT Evaluation and Treatment Plan dated 2/25/22, identified R282 would be seen for therapeutic exercises, neuromuscular reeducation, gait training therapy, and therapeutic activities five times per week for thirty days.

R282's PT visit notes from 2/25/22, through 3/9/22, were reviewed and identified PT services were provided 2/25/22, 2/28/22, 3/1/22, 3/2/22,

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21285	Continued From page 22 3/3/22 and 3/7/22. No therapy visit had been completed on 3/4/22, 3/8/22, and 3/9/22. When interviewed on 3/7/22, at 3:46 p.m. R282 stated he was not receiving therapy as often as was ordered and he was in his bed most of the time. During interview on 3/10/22, at 8:29 a.m. occupational therapy aide (OTA)-A stated the facility usually has physical therapy daily Monday through Friday but the physical therapy aide (PTA)-A was off for two weeks. OTA-A stated the physical therapist would be coming to the facility two times per week and would do PTA-A scheduled exercises with the residents on those days. During interview on 3/10/22, at 2:54 p.m. the director of nursing (DON) stated if therapy was not making visits with a resident as ordered they would need to notify the primary physician of the missed visits and obtain new orders. He was aware the PTA-A was not working for 2 weeks and he would notify R282's physician of the missed visits now. The facility policy Notification to Physician/Family?Resident Representative of Change in Resident Health Status with revision date November 2016, indicated the facility would notify the physician whenever there was a need to alter treatment significantly. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff obtain the needed orders/guidance to prevent significant weight loss. In addition the facility could ensure a	21285		

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21285	Continued From page 23 procedure to ensure resident's orders are carried out as ordered. 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 (21) days.	21285		
21426	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. This MN Requirement is not met as evidenced	21426		4/8/22

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21426	Continued From page 24 by: Based on interview and document review, the facility failed to ensure 3 of 5 employees (activities [A], dieatary aide [DA]-B, nursing assistant [NA]-C) were properly screened for tuberculosis signs and symptoms. In addition, the facility failed to complete a 2-step tuberculin skin test (TST) for 4 of 5 employees (A-A, DA-B, LPN-B, NA-C). This had the potential to affect all 32 residents residing in the facility. Findings include: Personnel records of five newly hired staff were reviewed and the following was found: Activities (A)-A was hired 11/21/21, however, a tuberculosis symptomology screening was not completed until 2/13/22. JS received step one TST on 2/13/22, but there was not evidence of a second TST. Dietary aide (DA)-B was hired 2/2/22, however, their record lacked evidence a tuberculosis symptomology screening was completed. DA-B received step one TST on 1/26/22, but there was not evidence of a second TST. Licensed practical nurse (LPN)-B was hired 1/24/22, a TST test was done on 1/14/22, but never read and would need to restart 2 step TST. Nursing assistant (NA)-C was hired 11/15/22, however, a tuberculosis symptomology screening was not completed until 3/3/22. NA-C's documented first TST was dated 3/3/22. On 3/10/22, at 4:18 p.m. the assistant director of nursing (ADON) stated A-A worked casual and fell through the cracks, other employees didn't get	21426	1. Activities (A), Dietary Aide (DA)-B and nursing assistant (NA)-C will be properly screened for tuberculosis signs and symptoms. 2. Employees A-A, DA-B, LPN-B and NA-C will complete a 2-step tuberculin skin test. 3. DON or designee will develop a TB prevention program that ensures all new employees have a baseline screening done. 4. All staff members will be audited to ensure that a baseline screening and 2-step tuberculin skin test are completed. 5. Audits of all new staff will be completed weekly for 4 weeks and then monthly for 2 months. 6. Results will be reviewed in monthly QAPI and changes will be made as necessary. 7. Date certain April 8, 2022.	

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21426	Continued From page 25 completed for other reasons or some of the paperwork may have been discarded. The facility's Facility Tuberculosis Risk Assessment for Health Care Settings identified baseline TB screening is required at the time of hire for all health care personnel. Baseline TB screening includes: an assessment for symptoms of active TB disease, assessing TB history, testing for the presence of infection by administatering either a two-step TST or single TB blood test. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise the TB prevention program and ensure new employees have a baseline screening done. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21426		

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	245138	A. BUILDING **01** B. WING _____	**03/08/2022**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted on 03/08/2022 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Boundary Waters Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, The Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/31/2022

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

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K 000	Continued From page 1 CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Boundary Waters Care Center is a 1-story building with no basement. The building was constructed in 1968, with an addition in 2002. Both buildings are of Type II(111) construction; therefore, the building was inspected as one building.	K 000		

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K 000	Continued From page 2 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 000		
K 351 SS=D	Sprinkler System - Installation 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, and staff interview, the automatic sprinkler system is not maintained per the 2012 edition of	K 351	1. Storage in the activities' storage room will be removed so that the sprinkler head has more than 6 inches of clearance.	4/8/22

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K 351	Continued From page 3 National Fire Protection Association (NFPA) Standard 101, Life Safety Code, section 9.7.5, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.5.6.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/08/2022, at 1:30 PM, it was revealed by observation that the height of the storage that is located in the activities storage room by the lounge was within 6 inches of the sprinkler head deflector that is located within that room. An interview with the Maintenance Supervisor verified this deficient finding at the time of the discovery.	K 351	2. All store rooms will be audited to ensure items are not stored to close to the sprinkler heads. 3. Audits or store rooms will be conducted by the Administrator or his designee 2x per week times two weeks, 1x per week for two weeks and then monthly for two additional months. 4. Results of these audits will be reviewed at monthly QAPI meetings and changes will be made as necessary. 5. Date certain April 8, 2022.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided	K 363		4/8/22

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K 363	Continued From page 4 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, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility had 1 of numerous corridor doors that were not maintained per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3, 19.3.6.3.10, and 19.3.6.3.11. This deficient 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	K 363	1. A magnetic hold open device that releases when the door is pushed or pulled will be installed on the Administrator's office door. 2. Date certain April 8, 2022.	

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K 363	Continued From page 5 verified this deficient finding at the time of the discovery.	K 363		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2 and 19.7.1.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/08/2022, at 12:08 PM, during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not conduct an overnight shift fire drill in the third calendar quarter. 2. On 03/08/2022, at 12:08 PM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was	K 712	1. Fire drills will be held at least quarterly on each shift. They will include varying conditions at expected and unexpected times. 2. Fire drills will include complete documentation of the emergency situation as well as the actions that were taken by the staff in response to the drill. 3. Fire drills will be audited by the Administrator or designee monthly x3. 4. Results of these audits will be reviewed at monthly QAPI meetings and changes will be made as necessary. 5. Date certain April 8, 2022.	4/8/22

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 6 revealed that the facility did not conduct an evening shift fire drill in the second calendar quarter. 3. On 03/08/2022, at 12:08 PM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not conduct an evening shift fire drill in the fourth calendar quarter. 4. On 03/08/2022, at 12:08 PM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did complete the documentation for the simulated overnight shift fire drill dated 09/08/2021. The documentation did not have the fire emergency situation information and the actions that were taken by the staff in response to this simulated fire drill. An interview with the Maintenance Supervisor verified these deficient findings at the time of the discovery.	K 712		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	K 901		4/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245138	A. BUILDING **01** B. WING _____	**03/08/2022**

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K 901	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/08/2022, at 1:45 PM, during a review of available documentation and an interview with the Maintenance Supervisor, it was revealed that the facility provided a utility risk assessment document that did not contain a complete list of the specific facility systems from NFPA 99 chapters 6 and 9 of the 2012 edition of NFPA 99, The Health Care Facilities Code and the related room categories and the correct risk assessments for the rooms within the facility. 2. On 03/08/2022, at 1:45 PM, during a review of available documentation and an interview with the Maintenance Supervisor, it was revealed that the facility provided a utility risk assessment document that did not contain a complete list of the electrical and gaseous patients/residents care equipment and the associated risk categories for the patients/residents as outlined in 2012 edition of NFPA 99, The Health Care Facilities Code chapters 10 and 11. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 901	1. The utility risk assessment document will be updated to contain a list of the specific facility systems from NFPA 99 chapters 6 and 9, the correct risk categories and the correct risk assessments for the rooms within the facility. 2. The utility risk assessment document will be updated to contain a complete list of the electrical and gaseous patients/residents care equipment and the associated risk categories for the patients/residents as outlined in 2012 edition of NFPA 99, The Health Care Facilities Code chapters 10 and 11. 3. Date certain April 8, 2022.	
K 918 SS=C	Electrical Systems - Essential Electric Syste	K 918		4/8/22

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K 918	Continued From page 8 CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff	K 918	1. Monthly emergency generator	

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K 918	Continued From page 9 interview, the facility failed to test and maintain the emergency generator per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/08/2022, at 11:44 AM, it was revealed by a review of available emergency generator test and inspection documentation and an interview with the Maintenance Supervisor that the facility provided incomplete documentation for the April 2021 monthly emergency generator test/inspection, which did not contain the observed conditions and recorded operational values for that tests and inspection. An interview with the Maintenance Supervisor verified this deficient finding at the time of the discovery.	K 918	tests/inspections will contain observed conditions and recorded operational values for all tests and inspections. 2. Monthly emergency generator tests/inspections will be audited by the Maintenance Supervisor or designee monthly x3. 3. Results of these audits will be reviewed at monthly QAPI meetings and changes will be made as necessary. 4. Date certain April 8, 2022.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power	K 920		4/8/22

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K 920	Continued From page 10 strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to monitor conditions affecting the facility's electrical system per NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, and NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2.3.6 (2) & (3), 10.2.4, and NFPA 70 (2011 edition), National Electrical Code, sections 400-8, 590.3(D). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/08/2022, at 1:11 PM, it was revealed by observation that there is a refrigerator that is located at the main nurses' station that is being used to store resident food stuffs that is plugged into an extension cord that is being used in place of permanent wiring. An interview with the Maintenance Supervisor verified this deficient finding at the time of the discovery.	K 920	1. Permanent wiring will be provided for the refrigerator that is located at the main nurses' station and the extension cord will be removed. 2. Date certain April 8, 2022.	