DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
March 7, 2024

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

RE: CCN: 245138
Cycle Start Date: January 25, 2024

Dear Administrator:

On February 27, 2024, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance.  Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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March 7, 2024

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

Re: Reinspection Results
Event ID:  1ZNH12

Dear Administrator:

On February 27, 2024 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 January 25, 2024.  At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
February 6, 2024

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

RE: CCN: 245138
Cycle Start Date: January 25, 2024

Dear Administrator:

On January 25, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable 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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Alex Warren, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Mobile: 651-279-5375 Office: 218-302-6186

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 25, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 25, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.**

## 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 electronic 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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

| 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 _____ | 01/25/2024 |

| 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 |
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| E 000 | Initial Comments<br><br>On 1/22/24 to 1/25/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 1/22/24 to 1/25/24 , a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. | F 000 | | |
| F 582 SS=D | Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must-- | F 582 | | 2/24/24 |

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

Electronically Signed | 02/15/2024

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

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| F 582 | Continued From page 1<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually | F 582 | | |

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| F 582 | Continued From page 2<br>resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) to 2 of 3 residents (R17, R137) reviewed whose Medicare Part A coverage ended while in the facility.<br><br>Findings included:<br><br>R17's Notice of Medicare Non-Coverage (CMS-10123), dated 11/15/23, indicated R17's last day of skilled services was on 11/17/23. The form was signed by resident representative (RR) and dated 11/15/23. In addition, R17's Advance Beneficiary Notice of Non-Coverage (ABN; CMS-R-131) had been provided which indicated a potential cost of over $329.48 / day to R17 if paying privately for care and services at the facility. However, R17's medical record lacked evidence the required CMS-10055 had been reviewed and/or provided to R17 prior to their Medicare Part A coverage ending.<br><br>R137's Notice of Medicare Non-Coverage (CMS-10123), dated 1/10/24, identified R137's last day of skilled services was on 1/12/24. The | F 582 | Corrective Action:<br>The facility has begun using the Skilled Nursing Facility Advance Beneficiary Notice CMS Form 10055 (SNFABN) in accordance with CMS guidelines.<br>Corrective Action as it applies to others:<br>A policy for Skilled Nursing Advance Beneficiary Notice was developed.<br>Staff members involved in the distribution, explanation, and documentation of the SNFABN CMS Form 10055 will receive training on the policy.<br>Prevent Recurrence:<br>The facility administrator or designee will audit each SNFABN form prior to its distribution, and upon completion of the form to ensure compliance with facility policy and CMS guidelines.<br>Ongoing Monitoring:<br>Audit results will be shared with the IDT during the QAPI meeting for recommendations for continued auditing.<br>Monitored by:<br>Administrator or designee | |

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| F 582 | Continued From page 3<br>form identified R137 signed on 1/10/24. In addition, R137's Advance Beneficiary Notice of Non-Coverage (ABN; CMS-R-131) had been provided which identified a potential cost of $418.65 / day to R137 if paying privately for care and services at the facility. However, R137's medical record lacked evidence the required CMS-10055 had been reviewed and/or provided to R137 prior to their Medicare Part A coverage ending.<br><br>During an interview on 1/23/24 at 3:53 p.m., social services designee (SSD) stated she was responsible to ensure the CMS-10123 and subsequent appeal notices, including the CMS-10055, were provided to residents. SSD reviewed R17's and R137's census reports and stated each resident had been covered with only Medicare Part A coverage and transitioned to a different payer source when their coverage was ended when the SNF determined they would no longer qualify for coverage. The SSD verified the CMS-10055 was not provided to R17 and R137. The SSD stated CMS-10055 was used up till 6 months ago when corporate staff told the facility to change to the CMS-R-131.<br><br>The facility's policy titled Notice of Medicare Non-Coverage, was requested but not provided. | F 582 | | |
| F 583 SS=F | Personal Privacy/Confidentiality of Records<br>CFR(s): 483.10(h)(1)-(3)(i)(ii)<br><br>§483.10(h) Privacy and Confidentiality.<br>The resident has a right to personal privacy and confidentiality of his or her personal and medical records.<br><br>§483.10(h)(l) Personal privacy includes | F 583 | | 2/24/24 |

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| F 583 | Continued From page 4<br>accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.<br><br>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.<br>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.<br>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to ensure the electronic medical record (EMR) was secured in a manner that prevented unauthorized individuals from viewing and or accessing confidential resident information contained within the EMR. This had the potential to affect all 31 residents residing at the facility.<br><br>Findings include: | F 583 | Immediate Corrective Action:<br>The EMAR was locked to prevent unauthorized individuals from viewing medical records.<br>Corrective Action as it applies to others:<br>A visual audit was conducted to ensure that other EMAR screens were locked to prevent the unauthorized viewing of confidential resident information.<br>Prevent recurrence: | |

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| F 583 | Continued From page 5<br><br>During an observation on 1/24/24 at 8:33 a.m., trained medication aide (TMA)-A walked away from the medication cart located in the hallway. The EMR was open and displayed resident information. TMA-A assisted another staff access a storage room around the corner and then returned to the medication cart.<br><br>During a continuous observation on 1/25/24 at 8:22 a.m., the medication cart in the hallway was unattended and the EMR was open and displayed a resident's medication list.<br>- 8:25 a.m., the cart was unattended and the EMR continued to display resident information.<br>- 08:29 a.m., no change, multiple staff walked by the medication cart and did not notice the open EMR.<br>- 8:31 a.m., TMA-A exited a resident room, stopped at cart, looked at screen, left EMR open, left cart unattended, and entered another resident room.<br>-8:34 a.m., TMA-A returned to the medication cart.<br><br>During an interview on 1/25/24 at 8:34 a.m., TMA-A acknowledged that they had left the EMR open and unattended. TMA stated it was easy to lock the screen and demonstrated how to lock and unlock the EMR with a few clicks. TMA-A stated the EMR needed to be locked for resident privacy and confidentiality and confirmed they should have locked the EMR when they stepped away from the medication cart. The EMR should be locked every time we step away from the medication cart.<br><br>During an observation on 1/25/24 at 9:57 a.m., the EMR on the medication cart in the hallway | F 583 | The policy for Resident Privacy and Confidentiality was reviewed and remains current.<br>Staff will be educated on the policy.<br>Ongoing Monitoring:<br>Random visual audits will be conducted to ensure that EMAR screens are locked when staff are not in attendance. Three (3) visual audits will be conducted as follows:<br>• 5x/week for 2 weeks<br>• 3x/week for 2 weeks<br>• 2x/week for 2 weeks<br>• Weekly x 4 weeks<br>A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations.<br>Monitored by:<br>DON or designee | |

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| F 583 | Continued From page 6<br>was noted to be unattended and displayed a resident's name and medication administration information. TMA-A exited a resident room from down the hallway and returned to the medication cart.<br><br>During an interview on 1/25/24 at 10:52 a.m., the director of nursing (DON) stated to be in compliance with HIPAA [Health Insurance Portability and Accountability Act (a federal law that restricts access to individuals' private medical information)], resident information needed to be protected and secured. The DON explained that their EMR had a built-in lock feature designed to secure their EMR and prevent unauthorized access or viewing of confidential resident information. The DON stated they expected staff to lock or close the EMR every time they stepped away from the EMR, no exceptions. This had the<br><br>The facility policy Privacy and Confidentiality dated 11/2016, identified residents had the right to have privacy and confidentiality of their personal and medical rights and their information would be safeguarded at all tim to ensure confidentiality. | F 583 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered | F 684 | | 2/24/24 |

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| F 684 | Continued From page 7<br>care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure provider orders to monitor blood pressure were followed for 1 of 5 residents (R3) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R3's quarterly Minimum Data Set (MDS) dated 1/11/24, identified intact cognition and diagnoses of essential hypertension, history of cerebral vascular attack (CVA), and schizoaffective disorder.<br><br>R3's care plan dated 3/22/18, identified the potential for medication side effects including hypotension (low blood pressure) with an intervention to monitor for orthostatic hypotension (low blood pressure upon standing).<br><br>R3's provider orders dated 4/8/21, identified an order for orthostatic blood pressure readings (one reading taken while seated and one minute later a reading taken after standing) to be taken on R3's shower day every 28 days and to make a progress note if not obtained.<br><br>R3's electronic health record did not reflect orthostatic blood pressure readings or notes regarding why it was not obtained.<br><br>During an interview on 1/24/24 at 1:47 p.m., the director of nursing (DON) stated she would expect the orthostatic blood pressure to be done if as ordered, and it was important because R3 took medication which may cause hypotension and they needed to track this because it | F 684 | Immediate Corrective Action:<br>An orthostatic BP was obtained for R3.<br>Corrective Action as it applies to others:<br>A chart review will be conducted to ensure other residents with physician's orders for orthostatic BP monitoring have had blood pressures obtained in accordance with the physician's order.<br>Prevent Recurrence:<br>The policy for Physician's orders was reviewed and updated regarding expectations<br>Nursing staff will be educated on the policy.<br>Ongoing Monitoring:<br>Random documentation audits will be conducted to ensure orthostatic BP's have been completed in accordance with physicians' orders. Audits will be conducted as follows:<br>• 5x/week for 2 weeks<br>• 3x/week for 2 weeks<br>• 2x/week for 2 weeks<br>• Weekly x 4 weeks<br>A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations.<br>Monitored by:<br>DON/Designee | |

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| F 684 | Continued From page 8<br>(orthostatic hypotension) put R3 at risk for falls.<br><br>A facility policy, Physician's Order - Recording dated May 2020, did not address expectations with following a provider order. | F 684 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to follow provider interventions for wound care for 1 of 2 residents (R8) reviewed for pressure ulcers.<br><br>Findings include:<br><br>R8's quarterly Minimum Data Set (MDS) dated 11/21/23, identified R8 as moderately cognitively impaired, was dependent on staff for transfers and repositioning, and had lower extremity impairment. R8's diagnoses included multiple sclerosis (autoimmune disease in which the insulating covers of nerve cells are damaged), | F 686 | Immediate Corrective action:<br>RN (A) administered a pillow and applied heel protectors to float R8's heels when in bed.<br>Corrective action as it applies to others:<br>Other residents with orders to float heels or to DON heel protectors were observed to ensure compliance with physician's orders for pressure relief.<br>Prevent Recurrence:<br>The Pressure Ulcer/Skin Integrity policy was reviewed and remains current.<br>Nursing Staff will be educated on the policy. | 2/24/24 |

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| F 686 | Continued From page 9<br>functional quadriplegia (weakness or paralysis leading to partial or total loss of function in the arms, legs, trunk and pelvis), nondisplaced transverse fracture of shaft of right tibia (bone fracture of the tibia in right leg), heart disease, diabetes mellitus, and an unstageable pressure injury on the right foot.<br><br>R8's care plan dated 1/2/24, identified R8 was at risk for impaired skin integrity including skin tears, bruising, and/or pressure injury. Intervention instructed staff to float R8's heel with boots or pillows on all sides of heels. Further, it instructed staff to check R8 for boots or pillow use on rounds and when needed. R8's care plan further identified R8 to have heel protectors on while in bed.<br><br>Care guide dated 1/24/24, identified R8's heels must be floated at all times when in bed and heel boots worn for pressure reduction when in bed.<br><br>Physician order dated 5/4/23, instructed staff to turn and reposition R8 twice on day and evening shifts and once during night shift. Order also stated any refusals by R8 should be documented in the chart.<br><br>Physician order dated 11/21/23, ordered nursing staff to apply green protective boots on R8 whenever in bed. Orders further instructed nursing staff to document when boots are on or off R8.<br><br>Physician order dated 12/15/23, medical doctor (MD) placed cast on R8's lower right leg and foot.<br><br>Physician order dated 1/2/24, instructed nursing staff to check R8's right heel cutout spot for | F 686 | Ongoing monitoring:<br>Random visual audits will be conducted to ensure pressure relieving interventions are administered as ordered. Audits will be conducted as follows:<br>• 5x/week for 2 weeks<br>• 3x/week for 2 weeks<br>• 2x/week for 2 weeks<br>• Weekly x 4 weeks<br>A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations.<br>Monitored by:<br>Don or designee | |

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| F 686 | Continued From page 10<br>drainage.<br><br>Provider progress note dated 1/2/24, MD identified blanchable red spot 7 centimeters (cm) in diameter on R8's right knee and ulceration 2 cm in diameter on resident's right heel. MD identified R8's cast to have cutouts over areas of concern on resident's right knee and right heel. MD instructed nursing staff to float R8's heel to take pressure off the heel.<br><br>Progress note dated 1/16/24 at 3:16 p.m., identified interdisciplinary team (IDT) discussed R8's pressure injury on right heel. IDT identified cutouts on cast as appropriate treatment and that R8's heels should be floated when lying in bed and continue to use pressure relief boot on R8's left foot.<br><br>On 1/23/24 at 11:19 a.m., R8 observed to be lying in bed. R8's right foot in a splint, on a pillow and not floated. Heel protector observed to be on chair in R8's room.<br><br>On 1/24/24 at 7:17 a.m., continuous observation began with the following observed:<br><br>-At 7:17 a.m., R8 was lying in bed with the door open and lights off. No staff observed to go into R8's room.<br><br>-At 7:31 a.m., R8 was lying in bed with the door open and lights off. No staff observed to go into R8's room.<br><br>-At 7:59 a.m., R8 was lying in bed with the door open and lights off. No staff observed to go into R8's room. | F 686 | | |

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| F 686 | Continued From page 11<br>-At 8:30 a.m., R8 was lying in bed with the door open and lights off. No staff observed to go into R8's room.<br><br>-At 8:43 a.m., activities assistant (AA)-A brought in breakfast tray to R8. AA-A placed breakfast tray on bedside table, and moved table closer to R8. AA-A did not offer to reposition R8. Heel protectors observed to be on chair in R8's room. An unidentified nurse entered the room and was observed moving R8 up towards head of bed. Unidentified nurse did not remove blanket from R8's legs, and did not check to see if R8 had heels floated or if wearing heel protectors. Heel protectors continued to be on chair in R8's room.<br><br>On 1/24/24 at 9:04 a.m., AA-A entered R8's room to give menu to resident. AA-A turned on television at R8's request. AA-A did not offer to reposition R8. Heel protectors continued to be on chair in R8's room.<br><br>On 1/24/24 at 9:24 a.m., AA-A and registered nurse (RN)-A entered R8's room. RN-A uncovered R8's legs and saw their heels were not floated. RN-A administered heel protectors and a pillow to float R8's heels.<br><br>During interview on 1/24/24 at 9:30 a.m., RN-A confirmed R8's legs were flat on the bed when she went into R8's room. RN-A stated R8's heels should always be floated and checked during every interaction with R8. RN-A further stated the expectation was R8's heels should be floated when in bed, and it was important to do so to promote healing of pressure injury.<br><br>During interview on 1/24/24 at 9:45 a.m., nursing assistant (NA)-C confirmed R8's heels should be | F 686 | | |

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| F 686 | Continued From page 12<br>floated at all times when in bed. NA-C also confirmed R8's legs were flat on the bed that morning.<br><br>During interview on 1/24/24 at 10:05 a.m., director of nursing (DON) expected staff to float R8's heels to promote healing and prevent further damage. DON also expected staff to reposition R8 every 2-3 hours. DON stated staff should notify nurse when R8 refuses cares and refusal should be documented in R8's chart.<br><br>During interview on 1/24/24 at 10:46 a.m., physician stated they expected nursing staff would follow orders for R8 and float heels when in bed.<br><br>Pressure Ulcer/Skin Integrity policy dated 4/2022, identified facility "will ensure a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from forming." | F 686 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, facility failed to ensure staff properly | F 689 | Immediate Corrective action:<br>NA-A received immediate reeducation on | 2/24/24 |

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| F 689 | Continued From page 13<br>utilized a total body mechanical lift for 1 of 2 residents (R15) reviewed for accidents.<br><br>Findings include:<br><br>R15's quarterly Minimum Data Set (MDS) dated 12/21/23, identified R15 was severely cognitively impaired, required substantial assistance with activities of daily living (ADLs), and was dependent on staff for transfers. R15's diagnoses included Parkinson's disease (progressive disease of the nervous system), heart disease, and dementia (progressive or persistent loss of intellectual functioning).<br><br>R15's care plan dated 1/8/24, identified R15 required use of a total body mechanical lift for transfers with assist of two staff.<br><br>R15's care guide dated 1/24/24, identified R15 required use of Hoyer lift (manufacturer of mechanical lifts) with an assist of two staff.<br><br>On 1/24/24 at 9:01 a.m., nursing assistant (NA)-A was observed pushing R15 in wheelchair to resident's room. NA-A left R15 in room and brought a total body mechanical lift into R15's room. NA-A closed R15's door. No other staff were observed to enter or exit room.<br><br>On 1/24/23 at 9:20 a.m., NA-A was observed to bring mechanical lift out of R15's room. NA-A pushed R15 in wheelchair out of resident's room and brought resident to the lounge. No other staff were observed to enter or exit room during this time.<br><br>During interview on 1/24/24 at 9:21 a.m., NA-A stated he brought R15 to their room to complete | F 689 | facility policy regarding the use of Mechanical Lifts.<br>Corrective action as it applies to others:<br>Education was provided to other nursing staff regarding facilities policy for the use of total body mechanical lifts.<br>Prevent recurrence:<br>The policy for the use of Mechanical Lifts was reviewed and remains current.<br>Nursing staff will be educated on the policy.<br>Ongoing monitoring:<br>Random observation audits will be conducted to ensure staff safely operate mechanical lifts in accordance with facility policy. Three (3) audits will be conducted as follows:<br>• 5x/week for 2 weeks<br>• 3x/week for 2 weeks<br>• 2x/week for 2 weeks<br>• Weekly x 4 weeks<br>A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations.<br>Monitored by:<br>Don or designee | |

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| F 689 | Continued From page 14<br>ADLs. NA-A confirmed he used the total body mechanical lift to transfer R15 to bed and back to wheelchair. NA-A volunteered he "should have had another staff to help with lift."<br><br>During interview on 1/24/24 at 12:07 p.m., NA-A stated he was not sure on the policy for safely transferring residents with total body mechanical lifts. NA-A further stated he felt confident in his abilities to safely transfer residents without the help of other staff.<br><br>During interview on 1/24/24 at 2:30 p.m., NA-B confirmed two staff were needed to use the total body mechanical lift with residents.<br><br>During interview on 1/25/24 at 9:13 a.m., director of nursing (DON) stated the training for use of total body mechanical lifts included videos of proper technique and demonstration of safe use. DON stated staff were expected to use two staff when using a total body mechanical lift to transfer a resident.<br><br>Mechanical Lifts (Total Body & Sit-to-Stand) policy dated 11/2022, indicated "a minimum of two staff will be used to operate all mechanical lifts at all times." | F 689 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. | F 880 | | 2/24/24 |

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| F 880 | Continued From page 15<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable | F 880 | | |

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| F 880 | Continued From page 16<br>disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure residents were offered proper hand sanitization prior to meals. This had the potential to impact all residents that consumed meals in the dining room.<br><br>Findings include:<br><br>During a continuous observation of the dining room on 1/24/24 from 8:26 a.m., to 9:26 a.m., residents were seated at three tables. Each resident was offered a clothing protector and assistance with meal setup and or consumption as needed. However, there were no observations of staff offering or of resident's hands being sanitized prior to meal consumption. The main entrance to the dining room had a sign on the door that read "be a germ buster wash your hands." Staff observed to be assisting residents | F 880 | Immediate Corrective action:<br>Staff were provided with immediate education regarding the need to ensure residents are offered the opportunity to sanitize hands prior to each meal.<br>Prevent Recurrence:<br>The facility policy for Dining and Food Service was updated to address resident hand sanitation prior to each meal service.<br>Staff will be updated on the policy.<br>Ongoing Monitoring:<br>Random weekly observation audits will be conducted to ensure staff offer residents the opportunity to sanitize their hands prior to eating. Audits will be conducted as follows:<br>• 5x/week for 2 weeks<br>• 3x/week for 2 weeks | |

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| F 880 | Continued From page 17<br>during this time included nursing assistant (NA)-A, NA-B, NA-C, NA-D, and activities aide (AA)-A and AA-B.<br><br>During a continuous observation on 1/24/24 12:05 p.m., to 12:51 p.m., residents were seated at four tables. There were no observations of residents already seated in the dining room or being brought into the dining room being offered to have their hands sanitized. Staff observed to be assisting residents during this included nursing assistant (NA)-A, NA-B, NA-C, NA-D, (AA)-A and AA-B and kitchen staff that assisted with passing beverages and food to residents.<br><br>During a continuous observation on 1/25/24 from 8:19 a.m. to 8:40 a.m., there was a large pump bottle of hand sanitizer located by the sink staff used to wash their hands. Staff offered residents clothing protectors but did not offer residents the opportunity to sanitize their hands prior to eating their meal. Staff observed to be assisting residents during this time included (NA)-A, NA-B, NA-C, NA-D, (AA)-A, and the physical therapist assistant (PTA)-D.<br><br>During an interview on 1/25/24 at 10:13 a.m., NA-D-stated they did not help residents sanitize their hands before meals because they were never taught to do that before meals during their orientation. NA-D indicated it would be important for residents to have their hands sanitized before eating to prevent the spread of germs and for good hygiene.<br><br>During an interview on 1/25/24 at 10:32 a.m., NA-B confirmed they had not been helping residents sanitize their hands before meals during meals, but indicated normally staff did offer hand | F 880 | • 2x/week for 2 weeks<br>• Weekly x 4 weeks<br>A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations.<br>Monitored by:<br>Don or designee | |

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| F 880 | Continued From page 18<br>sanitizer to residents before meals. It was important for residents to sanitize their hands before they ate for infection control.<br><br>During an interview on 1/25/24 at 10:41 a.m., the director of nursing (DON) stated residents should be offered an opportunity to have their hands sanitized before they eat meals. The sanitization of hands is important for infection prevention and control.<br><br>The facility policy Handwashing dated 11/2022, did not address resident hand sanitization.<br><br>The facility policy Dining and Food Service dated 10/2022, instructed staff "Prior to eating, assess resident's appearance at meals for hygiene issues as needed," but did not include instruction for resident hand sanitization prior to meals. | F 880 | | |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/23/2024. 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>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.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION | K 000 | | |

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

Electronically Signed | 02/15/2024

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<br>IS NOT REQUIRED.<br><br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>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.<br><br>The building has an automatic sprinkler system installed throughout and also has a fire alarm | K 000 | | |

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| K 000 | Continued From page 2<br>system with smoke detection throughout the corridor system and in the common spaces.<br><br>The facility has a capacity of 42 beds and had a census of 32 at the time of the survey.<br><br>The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: | K 000 | | |
| K 226 SS=E | Horizontal Exits<br>CFR(s): NFPA 101<br><br>Horizontal Exits<br>Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4.<br>18.2.2.5, 19.2.2.5<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain a clear path of egress system per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1 and 7.1.10.1. This deficient finding could have a patterned impact on the residents within the facility.<br><br>Findings include:<br><br>On 01/23/2024 at 10:45am, it was revealed by observation that there was medical equipment stored in the egress exit door D052. This exit will need to be cleared or decommissioned by a Facility Architect of Facility Engineer. | K 226 | 1. The medical equipment being stored in egress exit D052 and exit door #20 has been removed.<br>2. An audit of all other exit doors was completed with no other equipment found to be stored in these exits.<br>3. All staff will be educated that medical equipment may not be stored in between exit doors at any time.<br>4. The facility Administrator or designee will conduct audits 5x a week for two weeks, 3x a week for two weeks, 1x a week for two weeks and monthly for two months to ensure that exits are clear of equipment. | 2/24/24 |

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| K 226 | Continued From page 3<br>On 01/23/2024 at 11:09am it was revealed by observation that there was medical equipment stored in the egress exit door #20.<br><br>An interview with the Director of Maintenance verified these deficient findings at the time of discovery. | K 226 | 5. Results of these audits will be reviewed at QAPI. | |
| K 281 SS=D | Illumination of Means of Egress<br>CFR(s): NFPA 101<br><br>Illumination of Means of Egress<br>Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention.<br>18.2.8, 19.2.8<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to provide the level of lighting as required by the Life Safety Code, (NFPA 101) 2012 edition section 7.8.1.4. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 01/23/2024 at 11:15am, it was revealed by observation that the exterior lights for door # 22 of the exit discharges had only one bulb for illumination and/or was not back up with emergency generator power.<br><br>An interview with the Director of Maintenance verified these deficient findings at the time of discovery. | K 281 | 1. An additional light fixture is scheduled to be installed for door #22.<br>2. All other exits will be audited to ensure proper lighting.<br>3. Exits will be audited monthly for 3 months to ensure proper lighting is maintained.<br>4. Results of this audit will be reviewed at QAPI | 2/24/24 |
| K 346 SS=F | Fire Alarm System - Out of Service | K 346 | | 2/24/24 |

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| K 346 | Continued From page 4<br>CFR(s): NFPA 101<br><br>Fire Alarm - Out of Service<br>Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.<br>9.6.1.6<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of the available documentation and staff interview, the facility failed to implement a fire evacuation plan per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 01/23/2024 at 09:42am, during documentation review it was revealed that the facility was without a fire out of service policy that listed a 4 hour call requirement for a fire alarm system outage.<br><br>An interview with the Director of Maintenance verified these deficient findings at the time of discovery. | K 346 | 1. The facility does have a fire out of service policy that lists a 4 hour call requirement for a fire alarm system outage.<br>2. A copy of this policy was provided to the Director of Maintenance and also placed in the fire drill book and emergency plan. | |
| K 353<br>SS=F | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection | K 353 | | 2/24/24 |

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| K 353 | Continued From page 5<br>Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 01/23/2024 at 09:48am, it was revealed by a review of available documentation the facility failed to perform the quarter sprinkler system testing.<br><br>An interview with the Director of Maintenance verified these deficient findings at the time of discovery. | K 353 | 1. The quarterly sprinkler system testing is complete.<br>2. The Administrator or designee will conduct audits of completion of the sprinkler system testing quarterly for a period of one year.<br>3. Results of these audits will be reviewed at QAPI. | |
| K 363<br>SS=D | Corridor - Doors<br>CFR(s): NFPA 101 | K 363 | | 2/24/24 |

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| K 363 | Continued From page 6<br><br>Corridor - Doors<br>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 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.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. | K 363 | | |

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| K 363 | Continued From page 7<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 01/23/2024 at 11:09am, it was revealed by observation that storage room door 209 does not latch.<br><br>An interview with the Director of Maintenance verified these deficient findings at the time of discovery. | K 363 | 1. The storage room door 209 will be repaired/replaced so that it latches.<br>2. All other corridor doors will be audited by the Administrator or designee to ensure they have positive latching hardware.<br>3. The Administrator or designee will conduct audits of corridor doors monthly for a period 3 months to ensure proper operation of latches.<br>4. Results of these audits will be reviewed at QAPI. | |
| K 372<br>SS=F | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. | K 372 | 1. The penetrations in smoke compartments above doors C006, C027 and D051 are properly sealed. The Medical Gas Storage room is not considered part of | 2/24/24 |

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| K 372 | Continued From page 8<br>These deficient findings could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 01/23/2024 at 10:15am, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors C006, C027, and D051.<br><br>On 01/23/2024 at 11:20am, it was revealed by observation that there was a penetration running through wall in Medical Gas Storage room.<br><br>An interview with the Director of Maintenance verified these deficient findings at the time of discovery. | K 372 | Boundary Waters Care Center but was also properly sealed.<br>2. Audits will be conducted by the Administrator or designee to ensure that there are no other unsealed penetrations in facility smoke barriers.<br>3. The Administrator or designee will audit smoke barriers monthly for 3 months to ensure no unsealed penetrations.<br>4. Results of these audits will be reviewed at QAPI. | |
| K 521 SS=F | HVAC<br>CFR(s): NFPA 101<br><br>HVAC<br>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.<br>18.5.2.1, 19.5.2.1, 9.2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a | K 521 | 1. A fire damper inspection will be scheduled and completed.<br>2. The Administrator or designee will conduct an audit of the fire damper inspection report quarterly for one year.<br>3. Results of this audit will be reviewed at QAPI. | 2/24/24 |

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| K 521 | Continued From page 9<br>widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 01/23/2024 at 09:31am, it was revealed by a review of available documentation that the facility could not provide a fire damper inspection report.<br><br>An interview with the Director of Maintenance verified these deficient findings at the time of discovery. | K 521 | | |
| K 712 SS=F | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>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.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include: | K 712 | 1. Staff responsible for scheduling fire drills were re-educated to the Life Safety Code language that requires fire drills be conducted under varied times and conditions.<br>2. All future fire drills will occur under varied times and conditions.<br>3. The Administrator or designee will conduct audits monthly for one year to ensure fire drills are being conducted under | 2/24/24 |

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| K 712 | Continued From page 10<br>1. On 01/23/2024, at 12:15pm, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: 02/03/2023 at 17:35, 05/03/2023 at 17:01, 08/03/2023 at 17:35, and on 11/03/2023 at 17:09.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K 712 | varied times and conditions.<br>4. Results of these audits will be reviewed at QAPI. | |

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
February 6, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 1ZNH11

Dear Administrator:

The above facility was surveyed on January 22, 2024 through January 25, 2024 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:

Alex Warren, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Mobile: 651-279-5375 Office: 218-302-6186

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00587 | A. BUILDING: _____ B. WING _____ | 01/25/2024 |

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

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 1/22/24 to 1/25/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was 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 these orders and | 2 000 | | |

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| 2 000 | Continued From page 1<br>identify the date when they will be completed.<br><br>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.<br><br>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.<br><br>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 | 2 000 | | |

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| 2 000 | Continued From page 2<br>IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 2 590 | MN Rule 4658.0435 Subp. 1 Confidentiality of Clinical Records and Info<br><br>Subpart 1. Maintaining confidentiality of records. Information in the clinical records, regardless of form or storage methods, must be kept confidential according to Minnesota Statutes, chapter 13 and sections 144.335 and 144.651, and federal regulations. A resident's clinical information in a nursing home must be considered confidential but it must be made available to all persons in the nursing home who are responsible for the care of the resident. The clinical information must be open to inspection by representatives of the Department of Health and others legally authorized to obtain access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to ensure the electronic medical record (EMR) was secured in a manner that prevented unauthorized individuals from viewing and or accessing confidential resident information contained within the EMR. This had the potential to affect all 31 residents residing at the facility.<br><br>Findings include:<br><br>During an observation on 1/24/24 at 8:33 a.m., trained medication aide (TMA)-A walked away from the medication cart located in the hallway. The EMR was open and displayed resident | 2 590 | Corrected. | 2/24/24 |

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| 2 590 | Continued From page 3<br><br>information. TMA-A assisted another staff access a storage room around the corner and then returned to the medication cart.<br><br>During a continuous observation on 1/25/24 at 8:22 a.m., the medication cart in the hallway was unattended and the EMR was open and displayed a resident's medication list.<br>- 8:25 a.m., the cart was unattended and the EMR continued to display resident information.<br>- 08:29 a.m., no change, multiple staff walked by the medication cart and did not notice the open EMR.<br>- 8:31 a.m., TMA-A exited a resident room, stopped at cart, looked at screen, left EMR open, left cart unattended, and entered another resident room.<br>-8:34 a.m., TMA-A returned to the medication cart.<br><br>During an interview on 1/25/24 at 8:34 a.m., TMA-A acknowledged that they had left the EMR open and unattended. TMA stated it was easy to lock the screen and demonstrated how to lock and unlock the EMR with a few clicks. TMA-A stated the EMR needed to be locked for resident privacy and confidentiality and confirmed they should have locked the EMR when they stepped away from the medication cart. The EMR should be locked every time we step away from the medication cart.<br><br>During an observation on 1/25/24 at 9:57 a.m., the EMR on the medication cart in the hallway was noted to be unattended and displayed a resident's name and medication administration information. TMA-A exited a resident room from down the hallway and returned to the medication cart. | 2 590 | | |

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| 2 590 | Continued From page 4<br><br>During an interview on 1/25/24 at 10:52 a.m., the director of nursing (DON) stated to be in compliance with HIPAA [Health Insurance Portability and Accountability Act (a federal law that restricts access to individuals' private medical information)], resident information needed to be protected and secured. The DON explained that their EMR had a built-in lock feature designed to secure their EMR and prevent unauthorized access or viewing of confidential resident information. The DON stated they expected staff to lock or close the EMR every time they stepped away from the EMR, no exceptions. This had the<br><br>The facility policy Privacy and Confidentiality dated 11/2016, identified residents had the right to have privacy and confidentiality of their personal and medical rights and their information would be safeguarded at all time to ensure confidentiality.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should complete audits to ensure that resident information remains confidential at all times. The director of nursing or designee should conduct measurable audits for a specific amount of time of ensure compliance with resident confidentiality. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 590 | | |

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| 2 900 | Continued From page 5 | 2 900 | | |
| 2 900 | MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers<br><br>Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:<br><br>A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and<br><br>B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to follow provider interventions for wound care for 1 of 2 residents (R8) reviewed for pressure ulcers.<br><br>Findings include:<br><br>R8's quarterly Minimum Data Set (MDS) dated 11/21/23, identified R8 as moderately cognitively impaired, was dependent on staff for transfers and repositioning, and had lower extremity impairment. R8's diagnoses included multiple sclerosis (autoimmune disease in which the insulating covers of nerve cells are damaged), functional quadriplegia (weakness or paralysis leading to partial or total loss of function in the arms, legs, trunk and pelvis), nondisplaced | 2 900 | Corrected. | 2/24/24 |

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| 2 900 | Continued From page 6<br><br>transverse fracture of shaft of right tibia (bone fracture of the tibia in right leg), heart disease, diabetes mellitus, and an unstageable pressure injury on the right foot.<br><br>R8's care plan dated 1/2/24, identified R8 was at risk for impaired skin integrity including skin tears, bruising, and/or pressure injury. Intervention instructed staff to float R8's heel with boots or pillows on all sides of heels. Further, it instructed staff to check R8 for boots or pillow use on rounds and when needed. R8's care plan further identified R8 to have heel protectors on while in bed.<br><br>Care guide dated 1/24/24, identified R8's heels must be floated at all times when in bed and heel boots worn for pressure reduction when in bed.<br><br>Physician order dated 5/4/23, instructed staff to turn and reposition R8 twice on day and evening shifts and once during night shift. Order also stated any refusals by R8 should be documented in the chart.<br><br>Physician order dated 11/21/23, ordered nursing staff to apply green protective boots on R8 whenever in bed. Orders further instructed nursing staff to document when boots are on or off R8.<br><br>Physician order dated 12/15/23, medical doctor (MD) placed cast on R8's lower right leg and foot.<br><br>Physician order dated 1/2/24, instructed nursing staff to check R8's right heel cutout spot for drainage.<br><br>Provider progress note dated 1/2/24, MD identified blanchable red spot 7 centimeters (cm) | 2 900 | | |

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| 2 900 | Continued From page 7<br><br>in diameter on R8's right knee and ulceration 2 cm in diameter on resident's right heel. MD identified R8's cast to have cutouts over areas of concern on resident's right knee and right heel. MD instructed nursing staff to float R8's heel to take pressure off the heel.<br><br>Progress note dated 1/16/24 at 3:16 p.m., identified interdisciplinary team (IDT) discussed R8's pressure injury on right heel. IDT identified cutouts on cast as appropriate treatment and that R8's heels should be floated when lying in bed and continue to use pressure relief boot on R8's left foot.<br><br>On 1/23/24 at 11:19 a.m., R8 observed to be lying in bed. R8's right foot in a splint, on a pillow and not floated. Heel protector observed to be on chair in R8's room.<br><br>On 1/24/24 at 7:17 a.m., continuous observation began with the following observed:<br><br>-At 7:17 a.m., R8 was lying in bed with the door open and lights off. No staff observed to go into R8's room.<br><br>-At 7:31 a.m., R8 was lying in bed with the door open and lights off. No staff observed to go into R8's room.<br><br>-At 7:59 a.m., R8 was lying in bed with the door open and lights off. No staff observed to go into R8's room.<br><br>-At 8:30 a.m., R8 was lying in bed with the door open and lights off. No staff observed to go into R8's room.<br><br>-At 8:43 a.m., activities assistant (AA)-A brought | 2 900 | | |

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| 2 900 | Continued From page 8<br><br>in breakfast tray to R8. AA-A placed breakfast tray on bedside table, and moved table closer to R8. AA-A did not offer to reposition R8. Heel protectors observed to be on chair in R8's room. An unidentified nurse entered the room and was observed moving R8 up towards head of bed. Unidentified nurse did not remove blanket from R8's legs, and did not check to see if R8 had heels floated or if wearing heel protectors. Heel protectors continued to be on chair in R8's room.<br><br>On 1/24/24 at 9:04 a.m., AA-A entered R8's room to give menu to resident. AA-A turned on television at R8's request. AA-A did not offer to reposition R8. Heel protectors continued to be on chair in R8's room.<br><br>On 1/24/24 at 9:24 a.m., AA-A and registered nurse (RN)-A entered R8's room. RN-A uncovered R8's legs and saw their heels were not floated. RN-A administered heel protectors and a pillow to float R8's heels.<br><br>During interview on 1/24/24 at 9:30 a.m., RN-A confirmed R8's legs were flat on the bed when she went into R8's room. RN-A stated R8's heels should always be floated and checked during every interaction with R8. RN-A further stated the expectation was R8's heels should be floated when in bed, and it was important to do so to promote healing of pressure injury.<br><br>During interview on 1/24/24 at 9:45 a.m., nursing assistant (NA)-C confirmed R8's heels should be floated at all times when in bed. NA-C also confirmed R8's legs were flat on the bed that morning.<br><br>During interview on 1/24/24 at 10:05 a.m., director of nursing (DON) expected staff to float | 2 900 | | |

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| 2 900 | Continued From page 9<br><br>R8's heels to promote healing and prevent further damage. DON also expected staff to reposition R8 every 2-3 hours. DON stated staff should notify nurse when R8 refuses cares and refusal should be documented in R8's chart.<br><br>During interview on 1/24/24 at 10:46 a.m., physician stated they expected nursing staff would follow orders for R8 and float heels when in bed.<br><br>Pressure Ulcer/Skin Integrity policy dated 4/2022, identified facility "will ensure a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from forming."<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 900 | | |

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| 21385 | Continued From page 10 | 21385 | | |
| 21385 | MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance<br><br>Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure residents were offered proper hand sanitization prior to meals. This had the potential to impact all residents that consumed meals in the dining room.<br><br>Findings include:<br><br>During a continuous observation of the dining room on 1/24/24 from 8:26 a.m., to 9:26 a.m., residents were seated at three tables. Each resident was offered a clothing protector and assistance with meal setup and or consumption as needed. However, there were no observations of staff offering or of resident's hands being sanitized prior to meal consumption. The main entrance to the dining room had a sign on the door that read "be a germ buster wash your hands." Staff observed to be assisting residents during this time included nursing assistant (NA)-A, NA-B, NA-C, NA-D, and activities aide (AA)-A and AA-B.<br><br>During a continuous observation on 1/24/24 12:05 p.m., to 12:51 p.m., residents were seated at four tables. There were no observations of | 21385 | Corrected. | 2/24/24 |

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| | 00587 | A. BUILDING: _____ B. WING _____ | 01/25/2024 |

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

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| 21385 | Continued From page 11<br><br>residents already seated in the dining room or being brought into the dining room being offered to have their hands sanitized. Staff observed to be assisting residents during this included nursing assistant (NA)-A, NA-B, NA-C, NA-D, (AA)-A and AA-B and kitchen staff that assisted with passing beverages and food to residents.<br><br>During a continuous observation on 1/25/24 from 8:19 a.m. to 8:40 a.m., there was a large pump bottle of hand sanitizer located by the sink staff used to wash their hands. Staff offered residents clothing protectors but did not offer residents the opportunity to sanitize their hands prior to eating their meal. Staff observed to be assisting residents during this time included (NA)-A, NA-B, NA-C, NA-D, (AA)-A, and the physical therapist assistant (PTA)-D.<br><br>During an interview on 1/25/24 at 10:13 a.m., NA-D-stated they did not help residents sanitize their hands before meals because they were never taught to do that before meals during their orientation. NA-D indicated it would be important for residents to have their hands sanitized before eating to prevent the spread of germs and for good hygiene.<br><br>During an interview on 1/25/24 at 10:32 a.m., NA-B confirmed they had not been helping residents sanitize their hands before meals during meals, but indicated normally staff did offer hand sanitizer to residents before meals. It was important for residents to sanitize their hands before they ate for infection control.<br><br>During an interview on 1/25/24 at 10:41 a.m., the director of nursing (DON) stated residents should be offered an opportunity to have their hands sanitized before they eat meals. The sanitization | 21385 | | |

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| 21385 | Continued From page 12<br>of hands is important for infection prevention and control.<br><br>The facility policy Handwashing dated 11/2022, did not address resident hand sanitization.<br><br>The facility policy Dining and Food Service dated 10/2022, instructed staff "Prior to eating, assess resident's appearance at meals for hygiene issues as needed," but did not include instruction for resident hand sanitization prior to meals.<br><br>SUGGESTED METHOD OF CORRECTION: The infection preventionist (IP) could develop additional infection control surveillance and education on the importance of hand hygiene prior to meals. Audits could be done to ensure that hand hygiene and other infection control practices are routinely followed during meal times.<br><br>TIME PERIOD FOR CORRECTION: Twenty one (21) days. | 21385 | | |
| 21426 | MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control<br><br>(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 | 21426 | | 2/24/24 |

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| 21426 | Continued From page 13<br>Health shall provide technical assistance regarding implementation of the guidelines.<br><br>(b) Written compliance with this subdivision must be maintained by the nursing home.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to screen for tuberculosis (TB) for 1 of 5 employees and failed to ensure 3 of 5 employees received two Mantoux tuberculin skin tests (TST) with documented results prior to their start date.<br><br>Findings include:<br><br>Registered nurse (RN)-B was hired on 12/19/23. No documentation of initial screening or two step TST results were provided.<br><br>Nurse assistant (NA)-E was hired on 10/13/23. Documentation on the initial TST was done on 10/25/23, but was not resulted. The documentation of the second TST result was not provided.<br><br>Culinary aide (CA)-C was hired on 10/25/23. No documentation of 2nd TST test was provided.<br><br>During interview on 1/23/24 at 12:56 p.m., human resources director (HRD) stated all staff are given the screening form from the HRD and the new staff had to find a nurse that could administer the first TST, have it read in the necessary time | 21426 | 1. Administrator or designee will conduct an audit of all current staff to ensure a TB baseline screening and 2nd-step tuberculin skin test have been completed.<br>2. Education will be provided to staff responsible for ensuring that TB testing is completed on all new hires.<br>3. Administrator or designee will complete audits of all new staff for 8 weeks to review TB testing and ensure proper completion.<br>4. Results of these audits will be reviewed at QAPI. | |

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| 21426 | Continued From page 14<br><br>frame, and administer the second step. The HRD stated they had several new hires in the last two months of 2023 and forgot to audit the TST forms to confirm all were completed.<br><br>During interview on 1/23/24 at 1:11 p.m., executive director (ED) confirmed that only one TST step was done on 3 of 5 staff members prior to their start date.<br><br>The TST staff testing policy was requested and not provided.<br><br>Suggested method of correction: The director of nursing or designee could review and update systems for employee tuberculosis screenings. The director of nursing or designee could educate all appropriate staff. The director of nursing or designee could monitor to ensure ongoing compliance with tuberculosis policy and procedures.<br><br>Time period for correction: 21 days | 21426 | | |
| 21665 | MN Rule 4658.1400 Physical Environment<br><br>A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, facility failed to ensure staff properly utilized a total body mechanical lift for 1 of 2 residents (R15) reviewed for accidents. | 21665 | Corrected. | 2/24/24 |

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| 21665 | Continued From page 15<br>Findings include:<br><br>R15's quarterly Minimum Data Set (MDS) dated 12/21/23, identified R15 was severely cognitively impaired, required substantial assistance with activities of daily living (ADLs), and was dependent on staff for transfers. R15's diagnoses included Parkinson's disease (progressive disease of the nervous system), heart disease, and dementia (progressive or persistent loss of intellectual functioning).<br><br>R15's care plan dated 1/8/24, identified R15 required use of a total body mechanical lift for transfers with assist of two staff.<br><br>R15's care guide dated 1/24/24, identified R15 required use of Hoyer lift (manufacturer of mechanical lifts) with an assist of two staff.<br><br>On 1/24/24 at 9:01 a.m., nursing assistant (NA)-A was observed pushing R15 in wheelchair to resident's room. NA-A left R15 in room and brought a total body mechanical lift into R15's room. NA-A closed R15's door. No other staff were observed to enter or exit room.<br><br>On 1/24/23 at 9:20 a.m., NA-A was observed to bring mechanical lift out of R15's room. NA-A pushed R15 in wheelchair out of resident's room and brought resident to the lounge. No other staff were observed to enter or exit room during this time.<br><br>During interview on 1/24/24 at 9:21 a.m., NA-A stated he brought R15 to their room to complete ADLs. NA-A confirmed he used the total body mechanical lift to transfer R15 to bed and back to wheelchair. NA-A volunteered he "should have had another staff to help with lift." | 21665 | | |

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| 21665 | Continued From page 16<br><br>During interview on 1/24/24 at 12:07 p.m., NA-A stated he was not sure on the policy for safely transferring residents with total body mechanical lifts. NA-A further stated he felt confident in his abilities to safely transfer residents without the help of other staff.<br><br>During interview on 1/24/24 at 2:30 p.m., NA-B confirmed two staff were needed to use the total body mechanical lift with residents.<br><br>During interview on 1/25/24 at 9:13 a.m., director of nursing (DON) stated the training for use of total body mechanical lifts included videos of proper technique and demonstration of safe use. DON stated staff were expected to use two staff when using a total body mechanical lift to transfer a resident.<br><br>Mechanical Lifts (Total Body & Sit-to-Stand) policy dated 11/2022, indicated "a minimum of two staff will be used to operate all mechanical lifts at all times."<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents who require the use of a total body mechanical lift. The director of nursing or designee should conduct staff training and audits to ensure that these residents are being transferred appropriately and per facility policy. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21665 | | |

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