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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: OCUP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00587

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

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

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

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

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

6. DATE OF SURVEY **01/02/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Patricia Halverson, Unit Supervisor 01/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/19/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/01/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/22/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5138

On January 2, 2014 a Post CertificationRevisit (PCR) by review of the plan of correction, was completed to verify correction of the deficiencies issued pursuant to the standard survey completed on November 15, 2013. Based on the revisit we have determined the facility corrected the deficienceies pursuant to the November 15, 2013 standard survey, effective December 20, 2013. Ref to the CMS 2567b for health only.

Effective December 20, 2013, the facility is certified for 40 skilled nursing facility beds..

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5138

March 9, 2014

Ms. Lynn Hickey, Administrator
Boundary Waters Care Center
200 West Conan Street
Ely, Minnesota 55731

Dear Ms. Hickey:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program
Effective the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 24, 2014

Ms. Lynn Hickey, Administrator
Boundary Waters Care Center
200 West Conan Street
Ely, MN 55731

RE: Project Number 00587

Dear Ms. Hickey:

On December 5, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 15, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On January 2, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 15, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 20, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 15, 2013, effective December 20, 2013 and therefore remedies outlined in our letter to you dated December 5, 2013, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 218-302-6151 Fax: 218-723-2359

Enclosure

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 24, 2014

Ms. Lynn Hickey, Administrator
Boundary Waters Care Center
200 West Conan Street
Ely, MN 55731

RE: Project Number 00587

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On January 2, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 15, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 20, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 15, 2013, effective December 20, 2013 and therefore remedies outlined in our letter to you dated December 5, 2013, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 218-302-6151 Fax: 218-723-2359

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245138	A. Building B. Wing	1/2/2014

Name of Facility	Street Address, City, State, Zip Code
BOUNDARY WATERS CARE CENTER	200 WEST CONAN STREET ELY, MN 55731

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **12/20/2013**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **12/20/2013**	ID Prefix **F0249** Reg. # **483.15(f)(2)** LSC	Correction Completed **12/20/2013**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/20/2013**	ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **12/20/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/20/2013**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **12/20/2013**	ID Prefix **F0411** Reg. # **483.55(a)** LSC	Correction Completed **12/20/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/20/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By V **State Agency**	**Reviewed By** KA 10562	**Date:** 1/23/14	**Signature of Surveyor:**	**Date:**
Reviewed By **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 11/15/2013	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: OCUP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00587

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/15/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Theresa Amend, HFE NE II 12/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 01/17/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN# 24-5138

At the time of the standard survey completed November 15, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7715

December 5, 2013

Ms. Lynn Hickey, Administrator
Boundary Waters Care Center
200 West Conan Street
Ely, Minnesota 55731

RE: Project Number S5138024

Dear Ms. Hickey:

On November 15, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Pat Halverson, Unit Supervisor
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007

Telephone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 25, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 15, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 15, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal

regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245138	A. BUILDING _____ B. WING _____	11/15/2013

RECEIVED DEC 1 2013 MN Dept. of Health, Duluth

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. Census 28	F 000	OK 12/20/13 BCH **Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide toileting assistance for 1 of 1 residents (R48) reviewed for dignity. Findings include: R48's diagnoses included cerebral vascular accident, dementia, diabetes and osteoarthrosis.	F 241	**F241** • **R48 has had a skin assessment and new bowel assessment put in place. No noted skin impairment noted due to her incontinent bowel movement.** • **Residents at BWCC are to be toileted per their individual plan of care.** • **Staff have been educated on following toileting plan of care.** • **Weekly audits will be completed by DON/Designee to assure toilet schedules and residents request to be toileted for a BM are being followed. Audit findings will be reported to QAA monthly.** • **Date: 12-20-13**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lynn Hickey	Administrator	12-12-13

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

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	245138	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 241	Continued From page 1	F 241		

The quarterly bowel and bladder assessment dated 10/25/13, indicated R48 was continent of bowel, wore a pull up brief and needed extensive assistance with transfers, toileting, peri care and brief changes. The significant change Minimum Data Set (MDS) dated 10/30/13, indicated R48 had moderately impaired cognition with no signs or symptoms of delirium, behaviors or rejection of cares. R48 was always continent of bowel and required extensive assistance of one staff to transfer and toilet.

The care plan dated 10/30/13, indicated R48 was continent of bowel and required extensive assistance of one staff for toileting. The nursing assistant (NA) resident care guide indicated R48 was continent of bowel.

R48, interviewed on 11/12/13, at 3:15 p.m., reported an incident during the night shift of 11/3/13. R48 described calling for staff assistance to have a bowel movement. One staff person came in and stated they could not help R48, "You can go in your diaper and we'll clean you up later." The staff left and never came back. R48 had an incontinent bowel movement and was left in the soiled incontinent product all night. R48 did not call for assistance because staff said they would come back. R48 stated she was aware of the urge for a bowel movement and did not like having to go in her incontinent brief. R48 was nervous, could not sleep the rest of the night, and was embarrassed when the morning nurse came and had to provide incontinence care. R48 stated the incident was reported to the social worker.

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F 241	Continued From page 2 On 11/14/13, at 7:58 a.m. nursing assistant (NA)-A, stated R48 was continent of bowel. The director of nurses, interviewed on 11/14/13, 12:00 p.m., had no knowledge of the incident. The social worker was interviewed at 12:10 p.m. and verified R48's report, stating the incident was investigated and reported.	F 241	**F242** • **R36 was interviewed regarding bathing preferences and the bathing schedule was updated to reflect preferences. R55 was discharged from the facility per plan.** • **All residents and/or responsible parties were interviewed regarding bathing preferences and bathing schedule/type was updated based on their preferences.** • **All staff were re-educated on reporting changes in preferences via the Social Services communication book.** • **SS/Designee will re-interview residents/responsible party at each care conference time for bathing preferences.** • **SS/Designee will conduct weekly audits regarding bathing preferences. Audit findings will be reports to QAA monthly.** • **Date: 12-20-13**	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor resident choices of bathing type and/or frequency for 2 of 3 residents (R55, R36) reviewed for choices. Findings include: R55's request for more than one shower per week was not honored.	F 242		

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F 242	Continued From page 3 R55's diagnoses included essential tremor, stress incontinence, and chronic myeloid leukemia in remission. The annual Minimum Data Set (MDS) dated 8/22/13, indicated R55 was cognitively intact and required extensive assistance of one staff for bathing. The care plan dated 10/29/13, directed extensive assistance of one staff with bathing. The undated nursing assistant care guide sheet indicated R55 could shower on the Saturday evening shift. R55 was interviewed, on 11/12/13, at 6:22 p.m. and stated she only gets one bath or shower a week. R55 stated she asked nursing staff for an extra bath or shower, but had been told, "No", they could only do one shower per week. On 11/14/13, at 12:11 p.m. the social worker (SW)-C was interviewed and stated residents were asked about preference for frequency of bathing on admission and again at care conferences. SW-C stated R55 had not informed him that she would like more than one shower a week. On 11/15/13, at 8:44 a.m. the director of nursing (DON) was interviewed and stated she would expect nursing staff to inform her if a resident requested an extra shower. The facility was unable to provide a policy and procedure on resident choices.	F 242		

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F 242	Continued From page 4 R36 was not provided a tub bath per request. R36's diagnoses included degeneration of lumbar and lumbosacral intervertebral disc, anxiety state, polymyalgia rheumatica and osteoporosis. A quarterly MDS dated 10/14/13, indicated R36 had moderate cognitive impairment, required extensive assistance with personal hygiene activities, and needed physical help in part of bathing activity. A significant change MDS dated 4/25/13, indicated R36 felt it was very important to choose the type of bath. The plan of care revised 4/24/13, indicated R36 preferred a shower. A care conference progress note dated 10/24/13, indicated R36 preferred a bath. On 11/13/13, at 9:10 a.m. R36 was interviewed and stated the preference for a tub bath over a shower. The undated, posted bath schedule indicated R36 was scheduled to receive a weekly shower on Saturday morning. On 11/14/13, at 12:30 p.m. licensed practical	F 242		

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F 242	Continued From page 5 nurse (LPN)-A and the DON stated the social worker had just completed an audit on bathing preferences, type and time of day. LPN-A and the DON produced the audit revealing R36 preferred a tub bath. On 11/15/13, at 9:10 a.m. SW-C stated he was aware R36 preferred a bath over a shower from the 10/24/13, care conference. SW-C confirmed R36's bathing preference should have been communicated to nursing staff. On 11/15/13, at 10:12 a.m. the DON stated R36's care guide should have been changed when SW-C knew R36 was requesting a tub bath over a shower.	F 242		
F 249 SS=C	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State.	F 249	**F249** • **Facility has hired an Activity Director with the appropriate qualifications.** • **Date: 12-20-13**	

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F 249	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure the activities program was directed by a qualified professional. This had the potential to affect all 28 residents of the facility. Findings include: Review of resident council minutes for October, 2013, indicated the facility had a new activity director. The activity director, interviewed on 11/14/13, at 12:45 p.m., stated he took the responsibility for the activity department in October 2013, when the previous activity director left. The activity director identified two years as a part time activity aide as the only experience working in activities department. The administrator was interviewed on 11/14/13, at approximately 2:30 p.m. stated the previous activity director left in October 2013 and current staff picked up the responsibility. The administrator verified the need for a qualified activity director.	F 249		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279	**F279** • **All care plans have been reviewed for residents who are currently receiving Coumadin. All care plans have been updated to include the use of Coumadin, potential risks and monitoring of anticoagulant therapy.** • **Nursing staff were re-educated on care planning and monitoring related to the use of anticoagulant therapy.** • **DON/designee will audit care plans and Coumadin flow sheets weekly x 4 then monthly. Audit findings will be reported to QAA monthly.** • **Date: 12-20-13**	

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F 279	Continued From page 7 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan to address the use, potential risks and monitoring of anticoagulant therapy for 2 of 5 residents (R17, R64) whose medications were reviewed. Findings include: R17's current physician's orders included Coumadin (anticoagulant medication) 5 milligrams (mg) Monday and Friday, and 7.5 mg daily on Tuesday, Wednesday, Thursday, Saturday and Sunday for atrial fibrillation (irregular heartbeat).	F 279		

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F 279	Continued From page 8 Potential side effects of Coumadin therapy include excessive bleeding. The care plan dated 10/29/13, lacked direction for monitoring the use of Coumadin, including signs and symptoms of excessive bleeding. R64's diagnoses included atrial fibrillation. Physician orders dated 10/1/13, included Coumadin by mouth 1 time daily in the evening. A Coumadin Medication Record dated 11/11/13, indicated R64 was receiving 1.5 mg on Monday, Wednesday, and Friday, and 3 mg the rest of the week. R64's care plan dated 10/29/13, lacked direction for monitoring the use of Coumadin, including signs and symptoms of excessive bleeding. On 11/14/13, at 2:30 p.m. the director of nursing (DON) stated the care plan should include monitoring for unusual or excessive bruising and bleeding when a resident is receiving Coumadin.	F 279		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and	F 322	**F322** • **R21's medication has been reviewed by the MD/NP. An order has been received to crush and mix all medications in 100 ml water and administer per G-tube. Follow with 100 ml flush for each medication pass.** • **Nursing staff have been re-educated on new order and procedure to check g-tube placement prior to medication administration.** • **DON or designee will perform random weekly audits x 4 then monthly of medication administration and checking g-tube placement. Audit findings will be reported to QAA monthly** • **Date: 12-20-13**	

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F 322	Continued From page 9 (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly administer medications through gastrostomy (g-tube) feeding tube, and failed to ensure the g-tube was checked for placement prior to administration of medications for 1 of 1 residents (R21) reviewed for medication administration via g-tube. Findings include: R21's diagnosis included dementia, Parkinson disease, excessive oral secretions, and swallowing problems. The quarterly Minimum Data Set dated 10/11/13, indicated R21 had a feeding tube and did not eat or drink orally. The care plan dated 10/29/13, noted R21 was at risk for aspiration, required a g-tube, and was dependent with tube feeding, medication administration and water flushes.	F 322		

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F 322	Continued From page 10 On 11/14/13, at 8:20 a.m. licensed practical nurse (LPN)-B was observed to set up R21's medication to be administered through the g-tube. Eleven medications were crushed and combined in one cup with two ounces of water. LPN-B stated the order did not specify the quantity of water to be added to the medications or how much water was to be flushed before and after the medications. LPN-B added 100 cc of water to a large pitcher for flushing the g-tubing, donned gloves and disconnected the g-tube feeding. At 8:30 a.m. LPN-B flushed the g-tubing with 60 cc of water and administered the medication slurry via gravity followed by the remaining 40 cc of water. At 8:40 a.m., LPN-B stated the g-tube was not checked for placement when a bolus of medication was administered during a tube feeding. LPN-B did not know if the physician orders included specific directions for flushing the tubing before and after medication administration. Physician orders dated 1/1/13, indicated, "All meds/tablets must be crushed and added to water for slurry before giving meds via g-tube." The order did not direct mixing medications or include specific fluid amounts for mixing with medications or flushing the tubing. The policy dated April 2009, regarding administration of medications via g-tube indicated staff were to set up appropriate medications per physician's order and as per standard of practice, check for correct placement of tube, clear tube with the injection of approximately 10-30 cc of water, dissolve dry crushed medications in water,	F 322		

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F 322	Continued From page 11 instill by flow of gravity; Medications are not to be mixed and are to be given one at a time, followed by water as needed, re-clear tube after last medication with approximately 30 to 60 cc of water or as per physician's order. The director of nurses (DON), interviewed on 11/15/13, at 8:45 a.m., stated staff were to check g-tube placement before medication administration. Regarding R21's physician's orders, the DON stated the orders were not specific as to administration of multiple medications in one slurry.	F 322	**F323** • **R 27 and R17's beds were immediately moved further away from heat registers. All beds were audited for placement away from the heating registers.** • **The building heat was adjusted to have more heat from the ceiling vents and less from the individual registers.** • **All heating register temperatures were checked for appropriate temperatures.** • **Maintenance staff will monitor heating register temperatures on a weekly basis through the heating season.** • **Staff have been re-educated on assuring proper placement of beds in respect to heat registers.** • **Administrator/designee will audit bed placement 3x/week. Audit findings will be reported to QAA monthly.** • **Date: 12-20-13**	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure safe temperatures of heat registers in 2 of 19 resident rooms (R7, R17). Findings include: R7's bed was located against the heat register	F 323		

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F 323	Continued From page 12 that was hot to the touch. R7's diagnoses included cerebral vascular accident (stroke) with right sided hemiparesis (weakness) and osteoporosis. The annual Minimum Data Set (MDS) indicated R7 had severe cognitive impairment and required limited assistance of one staff with bed mobility and total assistance of one staff with transfers. R7 had impaired function of upper and lower extremities on one side. On 11/12/13, at 6:31 p.m. the right side of R7's bed was observed up against the heat register. The heat register was hot to touch. At 7:10 p.m., the plant maintenance manager (PMM) checked the surface temperature of the register and it was 141 degrees. On 11/12/13, at 7:53 p.m. the administrator was notified of the hot register and that R7's bed was against the register. At 7:54 p.m. the administrator stated maintenance staff were in the building to adjust the heat and R7's bed was moved away from the register. The PMM, interviewed on 11/14/13, at 2:00 p.m., stated the registers were heated by hot water and should not get that hot. The room thermostats for the hot water heat could be adjusted by residents, visitors or staff. The facility also had a hot air system with ceiling registers. The PMM stated the hot water temperatures were turned down and the hot air temperatures turned up to maintain a safe and comfortable level of heat. The PMM had	F 323		

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F 323	Continued From page 13 initiated a log of heat register temperature monitoring and the administrator planned to monitor heat registers and bed locations. On 11/15/13, at 9:15 a.m. the administrator was interviewed and stated there had been no monitoring of heat register temperatures prior to 11/12/13, when the problem was identified. On 11/15/13, at 9:50 a.m. nursing assistant (NA)-A and NA-C, stated resident beds were not routinely placed against the heat registers. R17's bed was within 7-9 inches of the heat register that was hot to the touch R17's diagnoses include dementia. The admission MDS dated 8/20/13, indicated R17 had severe cognitive impairment, and required extensive assistance of two staff for transfers and bed mobility. On 11/12/13, at 6:55 p.m., the heat register in R17's room felt hot to the touch. The PMM checked the surface temperature of the register and it was 140.7 degrees Fahrenheit (F). R17's bed was 9 inches away from the register at the head of the bed, and 7 inches from the register at the foot of the bed. On 11/12/13, at 7:24 p.m., the director of nursing verified the heat registers in R17 and R7's rooms were hot to the touch.	F 323		

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	245138	A. BUILDING _____ B. WING _____	11/15/2013

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

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F 356	Continued From page 14	F 356		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the required daily nurse staffing information. This had the potential to affect all 28	F 356	**F356** • **The facility changed its staffing posting form and is posting all required information on a daily basis.** • **Administrator/designee will audit staff posting forms 3x/week. Audit findings will be reported to QAA monthly.** • **Date: 12-20-13**	

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F 356	Continued From page 15 residents and the public. Findings include: The nursing staff posting for Wednesday November 13, 2013, did not specify the hours worked by registered nurses, licensed practical nurses or nursing assistants. The director of nurses, interviewed on 11/14/13, at 2:00 p.m. stated she was uncertain of the required staffing information to be posted. The administrator was interviewed on 11/15/13, at 8:20 a.m., and verified the posted nursing hours did not include the specific information about numbers shifts worked of each level of staff. The administrator stated there was no policy or procedure related to staff posting.	F 356		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer	F 411	**F411** • **R36 has follow up dental appointment scheduled.** • **All residents were reviewed for timely dental care services.** • **Each resident or responsible party will be re-interviewed at their care conference for need/request for dental follow up visit.** • **SS has been re-educated on making follow up appointments at time of request.** • **Administrator/designee will audit resident's dental appointments weekly to ensure timely follow up. Audit findings will be reported to QAA monthly.** • **Date: 12-20-13**	

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F 411	Continued From page 16 residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dental appointment was made in a timely manner for 1 of 2 residents (R36) reviewed for dental services. Findings include: R36's diagnoses included degeneration of lumbar and lumbosacral intervertebral disc and anxiety. A significant change Minimum Data Set (MDS) dated 4/25/13, indicated R36 had no oral or dental problems present. A quarterly MDS dated 10/14/13, indicated R36 had moderate cognitive impairment and required extensive assistance with personal hygiene activities. R36 was interviewed on 11/13/13, at 9:26 a.m. and reported needing to go to the dentist due to two broken teeth on the bottom. R36 further reported having a partial on the bottom teeth with the rest being natural teeth. R36 was observed to point to the two broken teeth on the bottom which held the partial in place. A care conference progress note dated 10/24/13, indicated R36 would like to get a dental check up, but had no particular dental concerns.	F 411		

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	245138	A. BUILDING _____ B. WING _____	11/15/2013

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F 411	Continued From page 17 On 11/15/13, at 9:10 a.m. social worker (SW)-C stated he was aware R36 had requested a dental appointment, however, the appointment had not been made. SW-C stated the dental appointment should have been made as soon as R36 made the request. On 11/15/13, at 10:12 a.m. the director of nursing (DON) stated R36's request for a dental appointment should have been honored and the appointment arranged right away. A dental services policy dated 4/1/08, indicated the facility would provide or obtain, from an outside resource, routine and emergency dental services to meet the need of each resident. The policy further indicated the facility would assist the resident in making appointments by arranging transportation to and from the dentist's office.	F 411		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	**F441** • **Education was completed with staff on proper hand washing technique and glove changing.** • **DON/Designee will conduct random care observations 3x/week to ensure proper hand washing technique and glove changing.** • **Audit findings will be reported to QAA monthly.** • **Date: 12-20-13**	

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F 441	Continued From page 18 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not provide hand hygiene and glove changes between personal hygiene and oral care for 1 of 4 residents (R18) reviewed for infection control. Findings included: R18's diagnoses included cerebral vascular accident (CVA) with right sided hemiparesis. The	F 441		

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F 441	Continued From page 19 quarterly Minimum Data Set (MDS) dated 9/16/13, indicated R18 had severe cognitive impairment, and required extensive assistance of one staff for personal hygiene, dressing, bathing and toileting. The care plan dated 10/29/13, directed extensive assistance of one staff for oral cares twice daily. During observation of R18's morning care on 11/14/13, at 8:24 a.m. nursing assistant (NA)-C entered the room and informed R18 that she wash going to get her washed up and ready for the day. NA-C prepared water in a basin, and NA-B entered the room. NA-C washed R18's front peri area, then both NAs turned R18, and NA-B washed R18's rectal area. Both NAs participated in removing a soiled incontinent brief and applying a clean brief, and dressing R18. When R18 was dressed, NA-C removed her gloves, and both NAs put a lift sling under R18. NA-B dumped the basin of soiled water into the sink, dried the basin, removed her gloves but did not wash her hands before providing oral care for R18. On 11/14/13, at 11:20 a.m. NA-B was interviewed and verified she did not wash her hands between pericare, contact with the soiled brief and oral care. On 11/15/13, at 8:44 a.m. the director of nursing (DON) was interviewed and stated she would expect nursing staff to wash their hands and change gloves when doing pericare and removing a soiled brief, when finishing personal hygiene, and prior to doing oral care.	F 441		

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F 441	Continued From page 20 The facility policy and procedure on hand washing dated 4/1/08, directed staff to wash their hands after each direct resident contact for which hand-washing is indicated by professional standards.	F 441		

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	245138	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/13/2013**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Boundry Waters Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Boundry Waters Care Center is a 1-story building with no basement. The building was constructed in 1968, with an addition in 2002. Both buildings are of Type II(111) construction, therefore the building was inspected as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 45 beds and had a census of 25 at the time of the survey.	K 000		

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

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.