Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 8, 2023

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

RE: CCN: 245138
Cycle Start Date: April 20, 2023

Dear Administrator:

On May 10, 2023, we notified you a remedy was imposed. On May 31, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 25, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 25, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 10, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 25, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 25, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies. Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 10, 2023

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

RE: CCN: 245138
Cycle Start Date: April 20, 2023

Dear Administrator:

On April 20, 2023, a survey was completed at your facility by the Minnesota Department(s) 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 constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 25, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 25, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 25, 2023.

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

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by May 25, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Boundary Waters Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 25, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 20, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C)

and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204 Fax: (651) 215-0525
Email: william.abderhalden@state.mn.us

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@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 _____	C 04/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/17/23 to 4/20/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop	E 004		5/25/23

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

Electronically Signed | 05/18/2023

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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E 004	Continued From page 1 and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure their emergency preparedness program (EPP) was reviewed and updated at least annually. This had the potential to affect all 31 residents residing in the facility, as well as all staff and visitors. Findings include: On 4/20/23, during review of EPP it was found the	E 004	1. The EPP was reviewed and revised. 2. A new review signature page was added to the front of the EPP binder to be used moving forward. 3. The policy for reviewing and updating the EPP was also added to the binder. 4. A monthly audit will be conducted to ensure updates to the EPP are made as necessary, as well as to evaluate the need for any additional updates.	

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E 004	Continued From page 2 facility lacked a revision date in the last year. During interview on 4/20/23 at 4:54 p.m., the administrator stated he had looked at the EPP binder but had not revise it in the last year. A policy for reviewing and updating the EPP was requested while on survey and not provided.	E 004	5. Results of these audits will be reviewed at monthly QAPI meetings.	
F 000	INITIAL COMMENTS On 4/17/23 to 4/20/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued. H51386122C (MN00088681) H51381323C (MN00091954) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 641	Accuracy of Assessments	F 641		5/25/23

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F 641 SS=D	Continued From page 3 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure their Minimum Data Set (MDS) assessment was accurately coded for 3 of 14 residents (R10, R25, R30) reviewed for resident assessment. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Resident Facility Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, "OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required." Section B: hearing, speech, and vision. "The intent of items in this section is to document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others and whether the resident experiences visual limitations or difficulties related to diseases common in aged persons." R10's quarterly MDS, dated 2/16/23, indicated resident was severely cognitively impaired and had diagnoses of Alzheimer's dementia and	F 641	F641 Accuracy of Assessments: Corrective Action: The MDS for R10, R25, AND R30 were corrected and resubmitted. Corrective Action as it Applies to Others: An audit will be completed to ensure accurate coding on the most recent MDS for other residents with difficulty hearing, pressure ulcers, and missing or broken teeth Prevent Recurrence: The MDS coordinator will receive reeducation regarding the RAI process and assessment accuracy. Date of Alleged Compliance: 5/25/2023 Ongoing Monitoring: Three random weekly audits will be conducted to ensure accurate coding of the MDS for hearing, pressure ulcers, and missing or broken teeth prior to each MDS batch submission. A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored by: DON/Designee	

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F 641	Continued From page 4 major depressive disorder. Section B indicated R10 had minimal difficulty hearing, had hearing aids and the ability to understand others. R10's care plan, dated 1/4/23, indicated a problem statement for hearing impairment. Interventions included staff placing hearing aids in resident's ears, ensure availability and functioning of adaptive communication equipment, message board, telephone amplifier, computer, or pocket talker. Furthermore, refer to audiology for hearing consult as needed. R10's provider order, dated 9/9/21, indicated resident was to have her hearing aid placed every morning, removed in the evening, and placed in the medication cart. During an interview on 4/17/23 at 3:29 p.m., R10 was unable to participate in conversation as she could not hear what was being said to her. R10 shook her head and stated she does not have her hearing aids, stated they "disappeared". During an observation on 4/18/23 at 3:24 p.m., R10 was awake and there were no hearing aids in her ears. R25 Section M: Skin Conditions intent: "The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant	F 641		

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F 641	Continued From page 5 pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program. Be certain to include in the assessment process, a holistic approach. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound." R25's significant change MDS assessment, dated 3/19/23, indicated R25 was moderately cognitively intact with diagnoses of diabetes mellitus, arthritis, and Alzheimer's disease. R25's MDS further indicated he required extensive assistance with bed mobility, toilet use, personal hygiene and was non-ambulatory, frequently incontinent of bowel and had an indwelling urinary catheter. R25's MDS further indicated he was at risk for pressure ulcers but did not currently have one. R25's care plan, dated 6/26/22, indicated R25 required an assist of one person for bed mobility, assist or encourage pressure relief as needed or accepted, to follow community skin protocol, to encourage repositioning in bed, and to get up for meals, activities, and therapy. During an observation on 4/19/23 at 9:55 a.m., NA-B and RN-A entered R25's room to assist with toileting and repositioning. R25 stated he had "kind of an ulcer in his rectal area, and it stings from time to time". Mepilex on R25's coccyx is dated 4/17/23. RN-A demonstrated the peri-wound was blanchable, though discolored a dusky, purple color. R25 stated it stung when the wound was cleansed with normal saline. RN-A measured the purple area at 6 cm by 6 cm., and the open area at 1 cm by 2 cm. RN-A further	F 641		

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F 641	Continued From page 6 stated it looked like a pressure sore to her and noted no drainage or odor from wound. R25 requested to be on his back, RN-A encouraged off-loading and placed a pillow as a wedge under his left side. R30 Section L: "Oral/Dental Status intent: This item is intended to record any dental problems present in the 7-day look-back period." R30's significant change MDS assessment, dated 1/20/23, indicated severely impaired cognition, and need for extensive assistance with personal hygiene. Section L indicated no dental problems (e.g., broken, or missing teeth). Care Area Assessment (CAA) for dental care was not triggered on the 1/20/23 MDS. R30's care plan indicated a problem statement for personal hygiene but lacked direction for providing personal hygiene. A progress note, dated 4/18/23, reported no observed difficulty chewing or swallowing. During an observation on 4/17/23 at 6:20 p.m., R30 was noted to have missing, broken with tooth fragments and discolored teeth on the upper jaw as observed during conversation while sitting lower than R30. During an interview on 4/19/23 at 11:00 a.m., RN-B identified responsibility for coordinating the MDS assessments. RN-B stated she did all the pain interviews and would ask about shortness of breath, eating, dentures, broken or missing teeth or dentures, glasses and hearing aids. RN-B	F 641		

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F 641	Continued From page 7 recalled doing a significant change assessment, on 1/20/23, for R30 and there were no complaints about her teeth though RN-B had observed there were dark colored teeth. During an interview, on 4/20/23 at 5:17 pm, the DON verified she would expect the MDS to be accurate regarding things like broken teeth, cavities, or hearing loss because it was important for the care planning. A policy and procedure regarding MDS and assessments was requested but not received.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		5/25/23

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F 657	Continued From page 8 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan timing and revision was completed for 2 of 2 (R10 and R11) residents reviewed for care planning. R11 was admitted on 6/10/21. R11's diagnoses included: Alzheimer's disease, glaucoma, and macular degeneration. R11's quarterly Minimum Date Set (MDS) assessment dated 1/19/23, indicated R11 was cognitively intact. R11 requires extensive assistance from one person for bed mobility, dressing, toilet use and personal hygiene. During an interview on 4/17/23 at 6:40 p.m., R11 stated she wanted to get up for the day after breakfast, and if she was sleeping, she wanted staff to wake her. R11 indicated she had told staff, multiple times to wake her after breakfast, but it doesn't happen. R11 said she is often left to sleep until lunch. R11 care conference documentation dated 1/17/23, included a care conference for R11. R11 's daughter, the director of nursing (DON) and SW were in attendance. R11's daughter requested that R11 not be left in bed in the morning and said R11 needs to be up in the morning. R11's care plan as off 4/20/23, included: Activities	F 657	F 657 Care Plan Timing and Revision: Corrective Action: The care plan for R11 was updated to include the resident's sleeping preferences and the care plan for R10 was updated regarding the resident's preference for hearing aids/Devices. Corrective Action as it Applies to Others: Other residents will be reviewed regarding sleeping preferences and individual care plans will be updated to reflect their personal preferences. Other residents with difficulty hearing will be reviewed to ensure their care plans reflect personal preferences regarding the use of hearing aids/devices. Prevent Recurrence: The policy for care plan Reviews/Conferences was reviewed and remains current. Licensed nursing staff will be educated on the policy by 5/25/2023 Date of Alleged Compliance: 5/25/2023 Ongoing Monitoring: Three random weekly audits will be conducted to ensure individualized care plans reflect resident preference for sleeping, and hearing aid/device use. • 5x/week for 2 weeks • 3x/week for 2 weeks • 2x/week for 2 weeks • Weekly x 4 weeks A summary of the audit results will be reviewed by the IDT during the monthly	

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F 657	Continued From page 9 of daily living: limited assistance for upper body dressing and total assist for lower body. R11's care plan lacked the preferences discussed in care conference. During an interview on 4/20/23 at 8:37 a.m., social worker (SW) stated members of the interdisciplinary team update the care plan. A preference for when a resident gets up in the morning would be something nursing would update or revise on the care plan. On 4/20/23 at 11:20 a.m., The director of nursing (DON) verified she was aware of R11 request to up after breakfast and not be left in bed. DON confirmed a resident/family personal preference including when they prefer to get up should go on the care plan and the care sheet. R10's quarterly MDS, dated 2/16/23, indicated resident was severely cognitively impaired and had diagnoses of Alzheimer's dementia and major depressive disorder. Section B indicated R10 had minimal difficulty hearing, had hearing aids and the ability to understand others. A care area assessment (CAA), dated 11/29/22, indicated impairment with receptive communication and hearing, and used a hearing aid as a communication device. R10's care plan, dated 1/4/23, indicated a problem statement for hearing impairment.	F 657	QAPI meeting for further recommendations. Monitored by: DON/Designee	

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F 657	Continued From page 10 Interventions included staff placing hearing aids in resident's ears, ensure availability and functioning of adaptive communication equipment, message board, telephone amplifier, computer, or pocket talker. Furthermore, refer to audiology for hearing consult as needed. R10's provider order, dated 9/9/21, indicated resident was to have her hearing aid placed every morning, removed in the evening, and placed in the medication cart. During an observation on 4/18/23 at 3:24 p.m., R10 was awake and there were no hearing aids in her ears. During an interview on 4/17/23 at 3:29 p.m., R10 was unable to participate in conversation as she could not hear what was being said to her. R10 shook her head and stated she does not have her hearing aids, stated they "disappeared". During an interview on 4/19/23 at 1:35 p.m., R10 stated she didn't have any hearing aids yet. R10 further stated she was upset because they should be in her ears, but they hadn't come back yet. During an interview on 4/19/23 at 1:45 p.m., registered nurse (RN)-A stated she didn't believe R10 had any hearing aids but thought the facility may have pocket talkers (a personal sound amplifying device). During an interview on 4/19/23 at 1:49 p.m., trained medication aid (TMA)-A stated R10's hearing aids used to be in her room but knew her family had been taking them home with them after they visited her because R10 would lose them.	F 657		

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F 657	Continued From page 11 During an interview on 4/19/23 at 2:45 p.m., the director of nursing (DON) stated R10 had refused to wear hearing aids and the DON was not sure where they were. During an interview on 4/20/23 at 8:19 a.m., social service designee (SD)-A stated R10 only had one hearing aid, and she had been using it for a while, but it would get lost, and her daughter was tired of dealing with it. SS-A further stated R10 didn't like wearing the hearing aid. The facility policy Care Plan Reviews/Conferences dated 10/22 read "The community will conduct a care plan review/conference at least quarterly, and as needed, that is interdisciplinary, provides in-depth review of the resident's plan of care, and provides an opportunity for resident and resident representative/or family discussion/input." The care plan policy included directive: Care plans may be written prior to the care plan meeting, knowing that input from resident or family may require it to be revised.	F 657		
F 661 SS=C	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to	F 661		5/25/23

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F 661	Continued From page 12 include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive discharge summary was provided at the time of discharge for 1 of 1 resident (R34) reviewed for closed records. Findings include: R34's admission Minimum Data Set (MDS) dated 12/4/22, indicated R34 was cognitively intact and needed extensive assistance with transfers, dressing, toilet use, and personal hygiene, limited assistance with bed mobility, and was independent with eating. R34's diagnoses included fracture of left femur, heart failure, hypertension, difficulty walking, weakness, dysphagia, and hearing loss.	F 661	F 661 Discharge Summary Corrective Action: R34 no longer resides in the facility Other Residents/Prevent Recurrence: The assessment titled “SNF - Discharge Summary / Recapitulation of Stay” and the policy for Resident Discharge were reviewed and remains current. Licensed staff will be educated on the assessment and policy by 5/25/2023. Date of Alleged Compliance: 5/25/2023 Ongoing Monitoring: Pre-discharge audits will be conducted to ensure residents who are scheduled to discharge from the facility receive a comprehensive discharge summary prior to discharge. Audits will be completed for each discharged resident for a period of 60	

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F 661	Continued From page 13 R34's progress note on 1/23/23 identified R34 was discharged from the facility to his home with his wife. R34's discharge papers consisted of a form titled Discharge Medication Instructions dated 1/23/23, which indicated seven medications three of which had a line through them. The signature line for R34 and the nurse indicating R34's medications had been explained and received by the facility remained unsigned by R34 or the nurse. During interview on 4/20/23 at 1:55 p.m., the director of nursing (DON) stated the facility only sends a medication list with the resident on discharge. The facility does not send a discharge summary or recapitulation of the residents stay. On 4/20/23 at 3:08 p.m., registered nurse (RN)-A stated the facility gives a resident who is discharging a medication list, an appointment card if the facility has one for the resident, and medications depending on the resident's insurance type. The facility's Discharging a Resident policy revised 10/2022, indicated the facility would develop and implement a discharge plan. The facility would effectively transition the resident to post-discharge care and reduce the factors leading to preventable re-admission.	F 661	days. A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored by: DON/Designee	
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary,	F 685		5/25/23

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F 685	Continued From page 14 assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure communication devices were available to maintain hearing and communication needs for 1 of 1 resident (R10) reviewed for hearing. R10's quarterly MDS, dated 2/16/23, indicated resident was severely cognitively impaired and had diagnoses of Alzheimer's dementia and major depressive disorder. Section B indicated R10 had minimal difficulty hearing, had hearing aids and the ability to understand others. A care area assessment (CAA), dated 11/29/22, indicated R10 had impairment with receptive communication and hearing, and used a hearing aid as a communication device. R10's care plan, dated 1/4/23, indicated a problem statement for hearing impairment. Interventions included staff placing hearing aids in resident's ears, ensure availability and functioning of adaptive communication equipment, message board, telephone amplifier, computer, or pocket talker. Furthermore, refer to audiology for hearing consult as needed. R10's provider order, dated 9/9/21, indicated	F 685	F 685 Treatment/Services to Maintain Vision/Hearing Corrective Action: A pocket talker was provided for R10 and the resident's provider was updated regarding the resident's choice of hearing devices. The order to place hearing aids daily was discontinued. Corrective Action as it Applies to Others: Other residents with difficulty hearing will be reviewed to ensure they are receiving the appropriate treatment and assistive devices to maintain hearing abilities per the resident's choice. Prevent Recurrence: The policy for Vision and Hearing was reviewed and remains current. Nursing staff will be educated on the policy by 5/25/2023. Date of Alleged Compliance: 5/25/2023 Ongoing Monitoring: Three random weekly audits will be conducted to ensure residents with hearing difficulty are receiving proper treatment and services to maintain hearing. • 5x/week for 2 weeks • 3x/week for 2 weeks • 2x/week for 2 weeks • Weekly x 4 weeks	

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F 685	Continued From page 15 resident was to have her hearing aid placed every morning, removed in the evening, and placed in the medication cart. During an observation on 4/18/23 at 3:24 p.m., R10 was awake and there were no hearing aids in her ears. During an interview on 4/17/23 at 3:29 p.m., R10 was unable to participate in conversation as she could not hear what was being said to her. R10 shook her head and stated she does not have her hearing aids, stated they "disappeared". During an interview on 4/19/23 at 1:35 p.m., R10 stated she didn't have any hearing aids yet. R10 further stated she was upset because they should be in her ears, but they hadn't come back yet. During an interview on 4/19/23 at 1:45 p.m., registered nurse (RN)-A stated she didn't believe R10 had any hearing aids but thought the facility may have pocket talkers (a personal sound amplifying device). During an interview on 4/19/23 at 1:49 p.m., trained medication aid (TMA)-A stated R10's hearing aids used to be in her room but knew her family had been taking them home with them after they visited her because R10 would lose them. During an interview on 4/19/23 at 2:45 p.m., the director of nursing (DON) stated R10 had refused to wear hearing aids and the DON was not sure where they were. During an interview on 4/20/23 at 8:19 a.m., social service designee (SD)-A stated R10 only	F 685	A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored by: DON/Designee	

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F 685	Continued From page 16 had one hearing aid, and she had been using it for a while, but it would get lost, and her daughter was tired of dealing with it. SS-A further stated R10 didn't like wearing the hearing aid. A policy titled, Vision and Hearing, dated September 2022 indicated residents would receive proper treatment and assistive devices to maintain vision and hearing abilities; the facility would assist the resident by making appointments and arranging transportation.	F 685		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (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 (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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning to prevent worsening pressure ulcers and the development of pressure ulcers for 4 of 4 residents (R25, R30, R6, R17) reviewed for pressure ulcers. Findings include:	F 686	F 686 Treatment and Services to Prevent/Heal Pressure Ulcers Corrective Action: Resident's R25, R30, R6, and R17 were repositioned to off-load pressure. Corrective Action as it Applies to Others: Other residents that are at risk for pressure ulcer development, and those	5/25/23

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F 686	Continued From page 17 R25's significant change Minimum Data Set (MDS) assessment, dated 3/19/23, indicated R25 had diagnoses which included diabetes mellitus, arthritis, Alzheimer's disease, and obstructive uropathy (when urine doesn't flow due to an obstruction). R25's MDS indicated he was moderately cognitively intact, required extensive assistance with bed mobility, toilet use, and personal hygiene. R25's MDS further indicated he was non-ambulatory, frequently incontinent of bowel and had an indwelling urinary catheter. R25's MDS indicated he was at risk for pressure ulcers but did not currently have one. R25's care plan, dated 6/26/22, indicated R25 required an assist of one person for bed mobility, assist or encourage pressure relief as needed or accepted, to follow community skin protocol, to encourage repositioning in bed, and to get up for meals, activities, and therapy. Facility document, titled Care Guide dated 4/13/23, indicated R25 should be side to side as much as possible when in bed and to encourage R25 to get out of bed. A facility form entitled Weekly Skin Check Tool, dated 3/17/23, noted no new skin issues. R25's provider orders indicated: - 5/30/22 calazime cream (a cream containing zinc oxide to form a temporary barrier against external irritants) to denuded skin on coccyx twice a day, notify MD with changes - 6/24/22 circulating air mattress for resident's bed - 4/4/23 turn resident side to side every two hours	F 686	with current pressure ulcers, will be reviewed to ensure turning and repositioning interventions are care planned accordingly, based on individual risk factors, to mitigate the risk of skin breakdown and promote healing. Prevent Recurrence: The Pressure Ulcer/Skin Integrity policy was reviewed and remains current. Staff will be educated on the policy and documentation for turning and repositioning by 5/25/2023. Date of Alleged Compliance: 5/25/2023 Ongoing Monitoring: Visual audits will be conducted to ensure turning and repositioning interventions are implemented based on individual risk factors and care planned interventions. 3 Random weekly audits will be conducted based on the following audit schedule: • 5x/week for 2 weeks • 3x/week for 2 weeks • 2x/week for 2 weeks • Weekly x 4 weeks A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored by: DON/Designee	

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F 686	Continued From page 18	F 686		

- 4/9/23 right coccyx wound 2 cm x 1 cm, cleanse with normal saline and apply Mepilex (an absorbent polyurethane foam dressing). Change every three days and as needed.

R25's wound assessments for April indicated the following:
-4/4/23 Indicated a new pressure wound with ten percent granulation tissue (new vascular tissue). Minimal amount of drainage. Skin surrounding wound with erythema (superficial reddening of the skin). Current treatment is 3x3 Mepilex. Resident rates the wound pain at a level 4. Positioning plan indicates staff to keep side to side as much as will allow in bed. Was given a cut-out cushion from OT for wheelchair.
-4/13/23 Wound number two: right side spot 0.5 cm MASD (Moisture Assoiciated Skin Damage). Blanchable. 100% granulation, surrounding skin intact. notes date of onset is 4/13/23. current treatment is Z-Guard Resident rates it as tender.
-4/13/23 Wound number one: MASD on coccyx, onset 2/24/23, blanchable, 100% granulation. no drainage. 1.5 cm by 1 cm surrounding skin intact. Current treatment apply Z-Guard (a petroleum and zinc oxide paste). on coccyx after every toileting. Check and change every two hours. Encourage daily to get out of bed into chair. Resident rates it as tender when touched.
-4/19/23 Documented as: spot on buttock as a pressure wound measures 2 centimeters (cm) by 1 cm wound with no drainage or odor. Some white moisture associated skin damage (MASD) around pink wound bed. Around the wound is purple blanchable tissue measuring 6 cm by 6 cm.

R25's progress note dated 4/6/23 indicated the interdisciplinary team (IDT) had met and

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F 686	Continued From page 19 determined the alteration in R25's skin was MASD. Interventions implemented included a cut-out cushion for R25's wheelchair, to cleanse wound and apply a foam dressing to be changed daily and as needed. Furthermore, R25 was to avoid lying on that area and staff were to get him up as much as he would allow. During interview on 4/17/23, at 6:51 p.m., R25 stated he had a painful sore on his bottom; he thought it developed about five months ago. On 4/19/23, R25 was continuously observed from 7:01 a.m. to 9:55 a.m. -7:01 a.m. R25 was lying on his back with the covers on, lights off, and curtains closed. -8:29 a.m. culinary director went into room with breakfast tray and left it on tray table. R25 lying flat in bed with blankets on. -8:43 a.m. Activity-A brought in a new calendar for resident and visited with him briefly. -8:54 a.m. RN-A brought R25 his medications. No repositioning was offered. -9:19 a.m. NA-B answered R25's call light. NA-B assisted resident to clean off his shirt and chest which had breakfast food on them. Handed R25 his harmonica and cell phone. NA-B tidied the room, put gloves on, checked catheter bag, collected dirty linen, and left the room. R25 was on his back and was not offered to be repositioned. -9:27 a.m. RN-A brought R25 a TUMS tablet. No repositioning was offered. -9:28 a.m. NA-B went into the room, checked the garbage, and left again. -9:55 a.m. NA-B and RN-A entered R25's room to assist with toileting and repositioning. R25 stated	F 686		

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F 686	Continued From page 20 he had "kind of an ulcer in his rectal area, and it stings from time to time". Mepilex on R25's coccyx is dated 4/17/23. RN-A demonstrated the peri-wound was blanchable, though discolored a dusky, purple color. R25 stated it stung when the wound was cleansed with normal saline. RN-A measured the purple area at 6 cm by 6 cm., and the open area at 1 cm by 2 cm. RN-A further stated it looked like a pressure sore to her and noted no drainage or odor from wound. R25 requested to be on his back, RN-A encouraged off-loading and placed a pillow as a wedge under his left side. During an interview on 4/19/23, at 9:50 a.m., NA-B stated a resident should be repositioned after two hours. During an interview on 4/19/23, at 9:53 a.m., RN-A stated residents should be repositioned every two hours, and R25 should have been turned because he had a sore bottom. RN-A verified R25 had not been repositioned that morning. R30 R30's significant change MDS assessment, dated 1/20/23, listed diagnoses of diabetes mellitus, rhabdomyolysis (when damaged muscle tissue releases proteins into the blood), polymyalgia rheumatica (an inflammatory disorder that causes muscle pain and stiffness), unspecified open wound of lower back and pelvis, and generalized muscle weakness. R30's MDS indicated severely impaired cognition, a stage 3 pressure ulcer, was at risk for pressure ulcers, needed extensive assistance for bed mobility, transfers, locomotion,	F 686		

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F 686	Continued From page 21 dressing, toilet use, and personal hygiene. R30's care plan indicated risk of skin impairment, with a goal to be free of serious complications, and for staff to assist/encourage pressure relief as needed/accepted, observe skin with AM/PM cares, pressure reducing cushion in wheelchair, and to follow wound treatment protocol. R30's provider order, dated 12/30/22, indicated left buttock/coccyx wound treatment as: Remove old dressings. Clean areas well using saline and gauze applying light pressure to wipe tissue clean and gently flush coccyx wound using saline flushes. Wash surrounding skin with soap and water. Cut linear strip of Exufiber Ag (a sterile non-woven gelling fiber antimicrobial) 4-5 cm in length and using cotton tipped applicator gently advance to wound base leaving external wicking. Secure in place with bordered Mepilex. Change every three days or if excessive drainage, increase frequency of dressing changes to every other day. R30's wound progress notes indicated improvement in wound measurements, with 1/3/23 being 1 cm by 0.5 cm by 1.5 cm and 4/18/23 being 0.4 cm by 0.2 cm by 0.3 cm. On 4/19/23 R30 was continuously observed from 7:03 a.m. to 10:29 a.m. -7:03 a.m. NA-A in room with R30. R30 was seated in wheelchair neatly dressed, hair was combed, socks and shoes were on. NA-A wheeled R30 to the dining room. -7:09 a.m. R30 remained in the dining room seated alone at a table alone with a beverage. -8:33 p.m. R30 seated at a table with other	F 686		

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F 686	Continued From page 22 residents who were eating their breakfast. -9:10 a.m. moved to another table in the dining room that had paper and colored pencils. -10:06 a.m. remained at the craft table in the dining room. -10:28 a.m. NA-A brought R30 from the dining room to her room. -10:29 a.m. NA-A and RN-A went into R30s room and closed the door. During an interview on 4/19/23 at 10:26 a.m. NA-A stated any resident who needed to be checked and changed is repositioned every two hours. If a resident refused, he would try reapproaching, and if not successful NA-A would chart the refusal and let the nurse know. NA-A stated R30 refused to be repositioned after breakfast as she wanted to color in the dining room and verified he hadn't told RN-A about R30's refusal yet. During an interview on 4/19/23 at 10:56 a.m. RN-A verified she placed a new dressing on R30's coccyx wound as the old one was not in place. RN-A stated there was no redness to R30's buttocks or back of thighs after this period of static sitting. Furthermore, RN-A stated there was no way for NAs to track resident repositioning times. Facility document, referred to as a care guide and dated 4/13/23, indicated R30 had intact skin, was incontinent of bowel and bladder, and to offer toilet and incontinent care upon rising in the morning, before meals and activities, and every two hours at night. R6	F 686		

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F 686	Continued From page 23 R6's quarterly MDS, dated 3/3/23, indicated diagnoses of non-Alzheimer's type dementia, depression, and a body mass index (BMI) of 19.9 percent or less. R6's MDS indicated moderately impaired cognition, had a non-ambulatory status and required extensive assistance for bed mobility, transfers, toilet use, and hygiene. R6 was incontinent of bowel and bladder and at risk for pressure ulcers. R6's care plan, dated 12/6/22, included a problem for potential of impaired skin integrity with a goal of having clean, dry, and intact skin through next review date and an intervention for incontinence care with brief changes. R6's provider orders indicated: 11/28/22 regular diet, regular texture, and thin liquids 11/28/22 give 120 mL fluid with med pass 3/28/23 nutritional supplement four ounces, two times per day On 4/19/23, R6 was continuously observed from 7:02 a.m. until 10:51 a.m. -7:02 a.m. door to room open, lights off, R6 lying in bed -7:11 a.m. staff looked in her room, did not wake her, left the room, and walked down the hall -7:16 a.m. NA-B entered R6's room to wake her and help with dressing, grooming, perineal hygiene, and transferring from the bed to the wheelchair -7:33 a.m. NA-B wheeled R6 to breakfast in the dining room -8:33 a.m. eating her breakfast in the dining room -8:45 a.m. remained in the dining room at the	F 686		

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F 686	Continued From page 24 table -9:06 a.m. wheeled to the TV area near the nurse's station -9:46 a.m. wheeled back to the dining room for trivia -10:26 a.m. remains in the trivia activity seated in wheelchair -10:51 a.m. NA-B brought R6 to her room and assisted her to a standing position with the EZ stand. NA-B verified R6's buttocks and backs of thighs are red from just below her buttocks to just above the backs of the knees. During an interview on 4/19/23, at 10:49 a.m., NA-B stated he didn't know if NA-A had already repositioned R6. NA-B verified it had been over three hours since he last repositioned R6. Facility document, referred to as a care guide and dated 4/13/23, indicated R6 was to be offered toileting and incontinent care upon rising in the morning, before meals and activities, and every two hours at night. During an interview on 4/19/23 at 2:45 p.m., the Director of Nursing (DON) stated staff should know when to turn residents and it was in their care guides. During the day she would expect about every two to three hours based on a routine of bringing residents to the bathroom upon waking, after meals, before activities, before bed, and every two hours at night. The DON confirmed there was not a system for employees to track turning and repositioning times for residents. Further stated tissue tolerance testing is not done, if a resident is at risk, they watch their weight and care plan for turning and repositioning.	F 686		

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F 686	Continued From page 25	F 686		

R17

R17's quarterly MDS assessment dated 2/7/23, indicated severe cognitive impairment needs extensive assistance with bed mobility, transfers, dressing, eating, toileting, and personal hygiene. R17 is incontinent of bowel and bladder and at risk for pressure ulcer but none present, has pressure reducing device for chair and bed. Diagnoses include Parkinson's disease, dementia, contractures to left hand, diabetes mellitus type 2, and chronic pain.

R17's care plan dated 1/19/23, indicated staff to provide incontinence cares as able upon rising, before meals, before activities, at bedtime, and every 2 hours at night as resident allows.

On 4/19/23, R17 was continuously observed from 7:39 a.m. to 10:41 a.m.

-7:39 a.m. nursing assistant (NA)- A and NA-B got R17 into wheelchair.
-7:42 a.m. NA-A left R17's room with R17 in wheelchair and brought him to the dining room.
-8:26 a.m. NA-B was assisting R17 with breakfast.
-8:51 a.m. R17 was wheeled to the commons area in his wheelchair and placed in front of the television.
-9:36 a.m. registered nurse (RN)-A took R17 into a private area to give eye drops. No repositioning offered or occurred.
-9:40 a.m. R17 was wheeled back to common area by RN-A.
-9:45 a.m. R17 was moved into dining area for

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F 686	Continued From page 26 activity. - from 9:51 a.m. to 10:35 a.m. R17 was noted to be sleeping on and off during activity. - 10:41 a.m. NA-A and RN-A removed R17 from his wheelchair and onto the toilet. RN-A assessed R17's buttocks and noted area was blanchable, no redness, and no open areas to the skin. During interview on 4/19/23 at 10:43 a.m., RN-A stated the facility tries to make sure that residents are repositioned every 2 hours. On 4/19/23 at 10:43 a.m. NA-A stated the last time R17 was repositioned was when he got out of bed. R17 should have been repositioned every 2 hours. On 4/20/23 at 1:10 p.m. director of nursing (DON) stated R17 should be repositioned every 2 hours. Facility policy entitled Pressure Ulcer/Skin Integrity, dated April 2022, indicated a resident will receive 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. Interventions will be implemented to mitigate the risk for skin breakdown based on individual risk factors which may include ....the implementation of individualized turning or repositioning schedules.	F 686		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in	F 688		5/25/23

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F 688	Continued From page 27 range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide range of motion (ROM) services to prevent a decline in ROM for 1 of 1 resident (R17) reviewed for ROM. This resulted in actual harm to R17 who had functional decline in ROM to the left hand. Findings include: R17's quarterly Minimum Data Set (MDS) dated 2/7/23, indicated R17 had severe cognitive impairment and required extensive assist with bed mobility, transfers, dressing, eating, toileting, and personal hygiene. R17 had functional limitations in ROM in upper and lower extremities on both sides; however, R12 had not received PROM (Passive range of motion (PROM) is the ROM that is achieved when an outside force (such as a therapist or a CPM machine) exclusively causes movement of a joint) services during the assessment period. Diagnoses included Parkinson's disease, dementia, diabetes mellitus type 2, contracture to hand, major	F 688	F 688 Increase/Prevent Decrease in ROM/Mobility Corrective Action: An order was obtained for R17 to be evaluated and treated by Physical Therapy for a decline in ROM. Corrective Action as it Applies to Others: Other residents with contractures will be evaluated to ensure the appropriate treatment to improve or prevent a decline in ROM is established, care planned, provided, and documented in the resident's medical record. Prevent Recurrence: The policy for Restorative Services was reviewed and remains current. Staff will be educated on the policy by 5/25/2023. Date of Alleged Compliance: 5/25/2023. Ongoing Monitoring: Documentation and visual audits will be conducted to ensure that treatment to improve or prevent a decline in ROM is provided based on the resident's individualized treatment plan. Three random weekly audits will be	

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F 688	Continued From page 28 depressive disorder, and chronic pain. R17's care plan dated 7/28/20, indicated R17 had a contracture to his left hand/wrist, with an intervention indicating to refer resident to therapy for range of motion. R17's Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 4/18/22, indicated R17 needed encouragement to participate and follow all occupational therapy recommendations for improved performance. R17's occupational therapy discharge summary dated 6/13/22, indicated discharge recommendations to continue with range of motion exercises. R17's left hand finger to palm measurements being completed on 5/25/22, indicated third digit finger to palm 3.75 centimeters (cm), 4th digit finger to palm 2.5 cm, and 5th digit finger to palm 5 cm. During an observation on 4/17/23 at 6:58 p.m., R17 had a brace on his left hand with his pointer finger straight and all other fingers curled into his palm. During an interview on 4/19/23 at 7:49 a.m., nursing assistant (NA)- A stated therapy does the hand exercises for the resident, and that he wouldn't be the one to complete any exercises with resident's hands. On 4/19/23 at 10:37 a.m., the director of nursing (DON) stated R17 didn't have range of motion exercises on his care sheet or care plan, but she was going to update them to reflect the need for range of motion.	F 688	conducted as follows: • 5x/week for 2 weeks • 3x/week for 2 weeks • 2x/week for 2 weeks • Weekly x 4 weeks A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored by: DON/Designee	

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F 688	Continued From page 29 On 4/19/23 at 11:10 a.m., NA-B stated the floor staff did not complete PROM with R17's left hand. On 4/19/23 at 1:28 p.m., the therapy director stated R17 had not been in therapy since June of 2022. She stated there were discharge instructions and she trained the nursing staff on what to do with R17's left hand. On 4/19/23 at 2:16 p.m., the DON stated her expectation was that the staff were to complete range of motion on R17. She stated she does not think it was communicated clearly and there is no documentation of any range of motion being done on R17's left hand. R17's therapy evaluation completed on 4/19/23 at 3:04 p.m. resulted in R17's left hand finger to palm measurements third digit finger to palm 3 cm, 4th digit finger to palm 2 cm, and 5th digit finger to palm 4 cm. During an interview on 4/19/23 at 3:41 p.m., the therapy director stated the measurements taken have indicated the contracture has gotten worse and she was requesting therapy orders. On 4/20/23 at 10:06 a.m., the therapy director stated if the facility would have done range of motion to R17's left hand he would have maintained the function he had in his left hand and wouldn't have lost function to his left hand. On 4/20/23 at 10:10 a.m., the medical provider stated there would be a decrease in range of motion if the facility didn't follow therapies recommendations to provide range of motion to R17's left hand.	F 688		

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F 688	Continued From page 30 Facility policy titled Restorative Program revised 5/2020, indicated all residents are supported to maintain or attain their highest level of function. Resident are assessed upon admission and at every care plan meeting for possible inclusion in restorative programs. Documentation on R17's range of motion to left hand was requested while on survey and not provided.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)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 failed to comprehensively assess to assure safety with smoking for 1 of 2 residents (R8) who was smoking outside the facility. Findings include: R8's significant change Minimum Data Set (MDS) dated 3/11/23, indicated R8 was cognitively intact and was a current tobacco user. R8 needed extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. Diagnoses included multiple sclerosis, chronic	F 689	F 689 Free of Accidents Hazards/Supervision/Devices Corrective Action: Resident R8 was assessed for her ability to smoke safely. Corrective Action as it Applies to Others: No other residents currently smoke. Prevent Recurrence: Any resident who wishes to smoke will be assessed for their ability to smoke safely off the facility grounds. Residents who are unable to smoke safely off facility grounds will be offered smoking cessation assistance. The Smoking policy was reviewed and remains current. The facility remains	5/25/23

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F 689	Continued From page 31 obstructive pulmonary disease, muscle weakness, and nicotine dependent. During the facility entrance conference on 4/17/23 at 2:51 p.m. the director of nursing (DON) stated the facility had one resident who smoked off campus. R8's care plan dated 2/14/23, indicated R8 smoked, and the facility would remind/educate on facility smoking policy and R8 had to agree to follow policy. During observation on 4/18/23 at 12:20 p.m., R8 was noted to have a clear container on bedside tray table with cigarettes in it. During interview on 4/18/23 at 12:20 p.m., R8 stated she was told by staff last night that she is not able to go outside and smoke alone anymore. On 4/19/23 at 7:49 a.m., nursing assistant (NA)-A said they helped R8 to go out and smoke sometimes, but she also took herself sometimes and would ring the bell when she was ready to come back inside. On 4/19/23 at 9:51 a.m. registered nurse (RN)-A stated R8 had to go off property to smoke with family. On 4/19/23 at 11:10 a.m. NA-B stated R8 must be able to smoke on her own. The facility staff would not be able to help her smoke. On 4/20/23 at 8:48 a.m., NA-C stated R8 smoked, and staff would open the door for R8, but she would have to be able to do the rest on her own.	F 689	non-smoking. Staff will be educated on the policy by 5/25/2023. Date of Alleged Compliance: 5/25/2023. Ongoing Monitoring: Audits will be conducted for any new admission, or current resident who expresses a desire to smoke to ensure they have been assessed for their ability to do so safely, off facility grounds, or have received education regarding smoking cessation if unable to exercise safe smoking practices. The IDT will review the smoking assessment of any resident who expresses a desire to smoke to ensure it is completed, or that smoking cessation was offered. The IDT will continue to audit all newly identified residents who wish to smoke for 60 days to ensure smoking assessments and/or cessation programs are offered. A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored by: Director of Social Service / Designee	

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	245138	A. BUILDING _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 32 On 4/20/23 at 9:39 a.m., administrator stated R8 was notified when she admitted that is was a non-smoking facility and she couldn't smoke on grounds. R8 then asked if she could go out with her family to smoke. Administrator told R8 that she would have to sign out and go off grounds. Staff are not to assist R8 to smoke. On 4/20/23 at 9:39 a.m., DON stated the facility does not have a smoking assessment on R8 as the facility is a non-smoking facility. During observation on 4/20/23 at 11:22 a.m., R8 was outside with an unknown visitor on facility property. The administrator went out to R8 with smoking policy in hand. R8 and unknown visitor moved off facility property. Administrator stated R8 had not started smoking at the time of the encounter. The facility Smoking policy revised 11/1/20, indicated the facility does not allow smoking on the premises. Prior or on admission the resident is made aware of the facility smoking policy. During orientation, all new employees are made aware of the facility's smoking policy. Residents that choose to admit as smokers are offered cessation programs.	F 689		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory	F 770		5/25/23

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F 770	Continued From page 33 services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review, the facility failed to ensure labs were drawn according to physician orders to determine therapeutic dosing for 1 of 5 (R7) residents reviewed for unnecessary medications. R7's quarterly minimum data set (MDS) assessment indicated she was cognitively intact and had diagnoses of diabetes mellitus, diabetic kidney complication, seizure disorder, hypothyroidism, and long-term use of insulin. R7's provider orders indicated: 9/1/17 - check vitamin D level, and fasting lipids every 12 months. Last lipid panel and vitamin D level done on 1/19/21. 2/27/19 - check hemoglobin A1C (a blood test indicating blood sugar levels over the past two to three months) every three months. Last hemoglobin AIC done 12/1/22. 2/27/19 - check thyroid stimulating hormone (TSH) every six months. Last TSH done on 9/14/22. During an interview on 4/19/23 at 2:45 p.m., the director of nursing (DON) verified it was important for labs to be checked for medication monitoring. Further stated they don't have a process for tracking labs due. During an interview on 4/20/23 at 5:00 p.m., pharmacy consultant (PC)-A verified labs were	F 770	F 770 Laboratory Services Corrective Action: The provider for R7 was updated regarding the lab and new lab orders were obtained. Corrective Action as it Applies to Others: A review will be conducted for other residents with orders for vitamin D, fasting lipids, HGB A1C, and TSH labs to ensure they have been completed as ordered. The respective providers will be updated for any resident who has not had labs drawn as ordered and new orders will be sought. Prevent Recurrence: The policy for Laboratory Results was reviewed and remains current. Staff will be educated on the policy by 5/25/2023. Lab draws will be completed as ordered by the provider. When lab orders are received, orders will be entered into the resident's treatment record for the corresponding day. A daily lab audit will be conducted to ensure labs are drawn as ordered. Date of Alleged Compliance: 5/25/2023 Ongoing Monitoring: Daily lab audits will be completed for a period of 60 days to ensure labs are completed and reported to the ordering provider as scheduled. A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored by: DON/Designee	

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F 770	Continued From page 34 important to be done timely for on-going medication therapy. Further, if there is a doctor order to do labs, then they should be done per the order. Facility policy entitled, Laboratory Results and Reporting, dated November 2022 indicated lab results were to be communicated with the ordering provider promptly. The policy didn't include procedures for tracking and obtaining labs.	F 770		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to store food in accordance with professional standards for food	F 812	F 812 Food Procurement, Store/Prepare/Serve-Sanitary Corrective Action: The refrigerator near	5/25/23

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F 812	Continued From page 35 service safety, monitoring of refrigerator temperatures. This had the potential to affect all residents who stored or consumed food and beverages from this refrigerator. Findings include: During observation on 4/20/23 at 8:11 a.m., a refrigerator near the nurse's station labeled for resident use only, had a brown, dry, and raised substance covering nearly the entire bottom of the refrigerator. There were two areas, each about one-and-a-half inches in size, of a dry, cream-colored, and bumpy substance on the bottom shelves. There is a thermometer on the door of the refrigerator reading 49 degrees. Pudding cups, Ensure beverages, and juice are all dated. During an interview on 4/20/23 at 8:15 a.m., Culinary director and director of nursing (DON) are interviewed. DON confirmed she did not know she was responsible for making sure this fridge was cleaned and temperature monitored. Culinary director stated he did not know it wasn't being cleaned or monitored. Policy and procedure for refrigerator cleaning and temperature monitoring was requested but not received.	F 812	the nurse's station was cleaned, the thermometer was moved from the door to the interior of the refrigerator, and a temperature log was provided. Prevent Recurrence: The policy titled Food – Sanitary Conditions was reviewed and remains current. Staff will be re-educated on the policy by 5/25/2023. The refrigerator will be cleaned nightly by the nursing staff, and the temperature will be logged. Concerns will be reported to the facility maintenance director for appropriate follow-up. Date of Alleged Compliance: 5/25/2023. Ongoing Monitoring: Weekly refrigerator audits will be conducted to ensure continued compliance with maintaining safe and sanitary storage of refrigerated foods. The frequency of audits will be completed as follows: • 5x/week for 2 weeks • 3x/week for 2 weeks • 2x/week for 2 weeks • Weekly x 4 weeks A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored by: DON/Designee	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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	F 880		5/25/23

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F 880	Continued From page 36 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 37 (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were maintained for 1 of 1 (R25) resident reviewed for infection control. Findings include: R25's significant change Minimum Data Set (MDS) assessment, dated 3/19/23, indicated he was moderately cognitively intact, required extensive assistance with bed mobility, toilet use, and personal hygiene. R25's MDS further indicated he was non-ambulatory, frequently incontinent of bowel and had an indwelling urinary catheter. R25's Diagnosis Report dated 4/20/23 indicated	F 880	F 880 Infection Prevention & Control Corrective Action: The provider for R25 was updated regarding the resident's current status and the diagnosis of enterocolitis due to clostridium difficile was resolved. Corrective Action as it Applies to Others: Other residents will be evaluated to determine the need for the use of transmission-based precautions. Transmission-based precautions will be implemented in accordance with accepted standards of practice. Prevent Recurrence: Under the direction of the medical director, the Enhanced Barrier Precautions policy has been discontinued and the IDT has	

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F 880	Continued From page 38 enterocolitis (infection of the small intestine) due to c-diff (clostridium difficile is an infection of the large intestine), not specified as recurrent. R25's care plan, dated 6/26/22, indicated R25 required an assist of one person for bed mobility, assist or encourage pressure relief as needed or accepted, to follow community skin protocol, to encourage repositioning in bed, and to get up for meals, activities, and therapy. During an observation on 4/17/23 at 6:22 p.m., nursing assistant (NA)-B was providing evening care to R25 without a gown or gloves on. NA-B transferred R25 with a sit-to-stand mechanical lift, assisted to brush his teeth, and wash his hands and face. During an observation on 4/19/23 at 9:19 a.m. NA-B assisted resident with cleaning off his chest and shirt, which were soiled from breakfast. Gave R25 his harmonica and cell phone. Straightened up the room and put on gloves to check catheter bag. Collected dirty linen and left the room. During an observation on 4/19/23 at 9:55 a.m. NA-B came in to assist resident. NA-B put on two pairs of gloves, but no gown, and emptied catheter bag into a graduate cylinder. Registered nurse (RN)-A came into R25's room and donned gown and gloves. NA-B removed gloves, cleaned hands, and left the room after RN-A whispered something to him. At 10:03 a.m. NA-B returned with isolation gowns, put one on and put the rest into a drawer. NA-B again left the room, with gown and gloves on, and came back with a box of gloves and donned three pairs. Assisted RN-A to provide incontinent care as R25 had been incontinent of loose, dark brown stool. NA-B	F 880	re-implemented a policy titled “Infection Prevention and Control Program – (General).” Staff will be re-educated on the current policy by 5/25/2023. Date of Alleged Compliance: 5/25/2023 Ongoing Monitoring: Weekly audits will be conducted to ensure staff complies with the use of gloves, gowns, and transmission-based precautions according to accepted standards of practice. Three random audits will be completed as follows: • 5x/week for 2 weeks • 3x/week for 2 weeks • 2x/week for 2 weeks • Weekly x 4 weeks A summary of the audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored by: DON/Designee	

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F 880	Continued From page 39 doffed the gown first and the gloves second and cleaned his hands with alcohol-based hand rub (ABHR). During an interview on 4/20/23 at 3:38 p.m., licensed practical nurse (LPN)-A stated R25 was colonized with c-diff and had outbreaks periodically. Furthermore, staff would be made aware of personal protective equipment (PPE) needs by the signs on R25's room door. Any direct care staff were to have gloves, gown, and mask on for providing care. LPN-A claimed responsibility for putting an isolation cart in place and would expect staff to wear all PPE to transfer or provide care to R25. During an interview on 4/19/23 at 9:29 a.m., NA-B stated the signs were on R25's door initially because he had c-diff, but he knew it was over because there was no longer an isolation cart outside the door. A facility document, referred to as a care guide and dated 4/13/23, indicated R25 had enhanced barrier precautions and a gown and gloves were needed for resident care and room cleaning. A document located on R25's door was titled, Contact Precautions from 2007 Guideline for Isolation Precautions, indicated the following for preventing transmission of infectious agents in health care settings: -Indicated contact precautions were in place. -Use of PPE (yellow highlighted areas): wear gloves whenever touching intact skin or surfaces and articles near the patient. Wear gowns whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or	F 880		

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F 880	Continued From page 40 equipment near the patient. Don gown upon entry into the room. Remove gown and observe hand hygiene before leaving the patient care area. -In long term care (LTC) settings, use disposable non-critical patient care equipment or implement patient-dedicated use of such equipment. Clean and disinfect equipment if not possible to have dedicated equipment. -Discontinue contact precautions after signs and symptoms of the infection have resolved or according to pathogen-specific recommendations. An undated document located on R25's door indicated enhanced barrier precautions consisted of: -clean hands with ABHR. -Providers and staff must also wear gloves and gown for high-contact resident care activities such as: dressing, bathing, transferring, changing linens, providing hygiene, changing brief or wound care. A policy entitled Enhanced Barrier Precautions (EBP), dated 10/4/22, described the use of EBP as an infection control intervention designed to reduce the transmission of resistant organisms by using targeted gown and glove use during high-contact resident care activities. To be employed when wounds or indwelling medical devises are used regardless of multi-drug resistant organisms (MDRO) status and/or if there is an infection or colonization with an MDRO. Signage will clearly indicate what type of PPE to use, during what activities to use it, and shall be posted outside the resident room. Make PPE available immediately outside the resident room, including masks for care that may generate a splash or spray (e.g., emptying a catheter bag).	F 880		

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 10, 2023

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

Re: Event ID: OM8911

Dear Administrator:

The above facility survey was completed on April 20, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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	245138	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/18/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/18/2023. 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. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 05/18/2023

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

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	245138	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/18/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Boundary Waters Care Center is a 1-story building with no basement. The building was constructed in 1968, with an addition in 2002. Both buildings are of Type II(111) construction; therefore, the building was inspected as one building. The building has an automatic sprinkler system installed throughout and also has a fire alarm system with smoke detection throughout the corridor system and in the common spaces.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 42 beds and had a census of 40 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 321		5/25/23

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K 321	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.6.5 and 8.5.6.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/18/2023 between 10:00am and 2:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above door D010. An interview with Maintenance Director verified these deficient findings at the time of discovery	K 321	1. The penetration running from one smoke compartment to another above door D010 has been sealed and fire stopped.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.	K 351		5/25/23

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K 351	Continued From page 4 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 04/18/2023, between 10:00am and 2:00pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in: 1) Activities Storage room - Door Number D058 2) Storage room - Door D073 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 351	1. Storage in the activities' storage room (D058) and utility storage room #315 (D073) will be removed so that the sprinkler head has more than 6 inches of clearance. 2. All store rooms will be audited to ensure items are not stored to close to the sprinkler heads. 3. Audits of store rooms will be conducted by the Administrator or his designee 2x per week times two weeks, 1x per week for two weeks and then monthly for two additional months. 4. Results of these audits will be reviewed at monthly QAPI meetings and changes will be made as necessary.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at	K 712		5/25/23

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K 712	Continued From page 5 least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills 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. Findings include: On 04/08/2023, between 10:00am and 2:00pm, it was revealed by a review of available documentation that fire drills were not completed: second shift missing third quarter (July - September) and fourth quarter (October - December) drills completely. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	1. Fire drills will be held at least quarterly on each shift. They will include varying conditions at expected and unexpected times. 2. Fire drills will include complete documentation of the emergency situation as well as the actions that were taken by the staff in response to the drill. 3. Fire drills will be audited by the Administrator or designee monthly x3. 4. Results of these audits will be reviewed at monthly QAPI meetings and changes will be made as necessary.	
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored	K 741		5/25/23

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K 741	Continued From page 6 and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement a staff smoking policy per NFPA 101 (2012 edition), Life Safety Code section 19.7.4. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 04/18/2023, 10:00am and 2:00pm, it was revealed by observation that the smoking was occurring by entry door 21 as evident by discarded cigarette butts and a visible pack of cigarettes. An interview with the Maintenance Director	K 741	1. All staff will be re-educated to the facility smoking policy. 2. Entry door 21 will be cleaned of smoking materials. 3. Audits of compliance to the facility's smoking policy will be conducted daily for two weeks, 3x per week for two weeks, 1x per week for two weeks and monthly for two months. 4. Results of these audits will be reviewed at monthly QAPI meetings and changes will be made as necessary.	

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K 741	Continued From page 7 verified this deficient finding at the time of discovery	K 741		