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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VLUG

Facility ID: 00587

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/22/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NE II 06/12/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 07/25/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/27/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/27/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245138
June 13, 2017

Mr. Adam Masloski, Administrator
Boundary Waters Care Center
200 West Conan Street
Ely, MN 55731

Dear Mr. Masloski:

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

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective March 7, 2017 the above facility is certified for or recommended for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 skilled nursing facility beds.

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

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

Please contact me if you have questions related to this eNotice.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
email: Kamala.Fiske-Downing@state.mn.us

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 13, 2017

Mr. Adam Masloski, Administrator
Boundary Waters Care Center
200 West Conan Street
Ely, MN 55731

RE: Project Numbers S5138027 and H5138016

Dear Mr. Masloski:

On February 13, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 26, 2017 that included an investigation of complaint number H5138016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 22, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 26, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 7, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 26, 2017, effective March 7, 2017 and therefore remedies outlined in our letter to you dated February 13, 2017, will not be imposed.

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

Please contact me if you have questions related to this eNotice.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

June 13, 2017

Mr. Adam Masloski, Administrator
Boundary Waters Care Center
200 West Conan Street
Ely, MN 55731

Re: Reinspection Results - Project Numbers S5138027, H5138016

Dear Mr. Masloski:

On March 22, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 26, 2017, that included an investigation of complaint number H5138016, with orders received by you on February 13, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please contact me if you have questions related to this eNotice.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VLUG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00587

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

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

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

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

6. DATE OF SURVEY **01/26/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **42** (L18)
13.Total Certified Beds **42** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NEII 02/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/27/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5138

On January 26, 2017, a standard survey was completed at this facility by the Minnesota Departments of Health and Public Safety to determine if the 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 this facility to be isolated
deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level

In addition an investigation of complaint number H5138016 was conducted and found to be substantiated at F309.

Refer to the CMS 2567 forms for both health and life safety code, along with the facility's plan of correction. Post Certification Revisit to follow.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 13, 2017

Mr. Adam Masloski, Administrator
Boundary Waters Care Center
200 West Conan Street
Ely, Minnesota 55731

RE: Project Number S5138027 and H5138016

Dear Mr. Masloski:

On January 26, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the January 26, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5138016 that was found to be substantiated at F309.

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 7, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 26, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 26, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Sincerely,

Mark Meath

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

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 01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Investigation of complaint H5138016 was completed. The complaint was substantiated. Deficiency issued at F309.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 157		3/7/17

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

Electronically Signed | 02/16/2017

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 01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a family representative was informed of a change in treatment for 1 of 3 residents (R12) interviewed for notification of change in status. Findings include:	F 157	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable	

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 01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 On 1/24/17, at 12:01 p.m. family member (FM)-G stated the family was not informed that oxygen therapy was initiated for R12. R12's Medical Diagnosis list printed 1/26/17, indicated R12's diagnoses included other nonspecific abnormal finding of lung field and atrial fibrillation (irregular heart beat). R12's Medication Review Report dated 1/26/17, indicated R12 had a physician's order received 1/20/17, for oxygen at 2 liters per minute (LPM) via nasal cannula every shift for low oxygen saturation due to a tumor. R12's Treatment Administration Record (TAR) for 1/17, indicated oxygen therapy was initiated during the day shift on 1/17/17, to keep oxygen saturations greater than 90%. The TAR indicated the oxygen order was changed to the physician's order on 1/20/17. R12's Progress Notes dated 1/10/17, indicated R12's oxygen saturations were 92% on oxygen at 1 LPM per nasal cannula. R12's Progress Notes dated 1/13/17 and 1/15/17, indicated R12 continued with oxygen therapy. R12's Progress Notes lacked documentation regarding notification of R12's family regarding the start of oxygen therapy, but indicated R12's family was in to visit on 1/15/17. On 1/25/17, at 7:00 a.m. R12 was observed sitting in a reclining chair near the nurse's station with oxygen on per nasal cannula. On 1/25/17, at 2:59 p.m. the director of nursing (DON) verified family members were to be notified of a resident's change in condition and	F 157	state and federal regulatory requirements. 1. Oxygen was started on 1/10/17 for R12. The facility failed to document notification to the family of a change in condition for R12. The family was updated on R12's decline in condition and chose to place R12 on Hospice. R12 has passed away. 2. Nursing staff have been educated on the facility policy regarding Notification to Physician/Family/Resident Representative of change in Resident Health Status. 3. All residents have the potential to be affected. The facility reviewed all residents who had a change in condition in the last 14 days to ensure that documentation of family notification was completed. 4. 3 random audits of documentation for family notification for a change in condition will be completed by the DON or designess weekly for four weeks then monthly for 3 months. 5. DON or designee will report audit results and trends of all audits to QA&A committee for review and follow up as needed. 6. Completion date 3/7/17	

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F 157	Continued From page 3 treatments, and the notification should be documented in the progress notes. On 1/26/17, at 11:01 a.m. the DON further verified R12's progress notes did not indicate the family had been notified of the change in status when the oxygen therapy was initiated. The DON stated she would expect the family would be notified and the notification to be documented in the progress notes. The facility policy and procedure for Notification to Physician/Family/Resident Representative of Change in Resident Health Status revised 11/16, directed staff to notify the resident representative or interested family when there is an acute illness or a significant change in the resident's physical status, such as a deterioration in health , or if there is a need to alter treatment significantly.	F 157		
F 285 SS=D	483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related	F 285		3/7/17

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F 285	Continued From page 4 condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires	F 285		

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F 285	Continued From page 5 specialized services for intellectual disability. (2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. (3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3)	F 285		

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F 285	Continued From page 6 or is a person with a related condition as described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Level II Pre-Admission Screening and Resident Review (PASRR) was completed for 1 of 1 resident (R8) upon admission to the facility. Findings include: R8's care plan dated 6/28/16, indicated diagnoses of moderate intellectual disability and chronic encephalopathy caused by prolonged fever as a child. A quarterly Minimum Data Set (MDS) dated 11/30/16, indicated R8's cognition was severally impaired. A review of R8's OBRA (Omnibus Budget Reconciliation Act) Level I Criteria-Screening for Developmental Disabilities or Mental Health form dated 6/9/16, indicated R8 had a developmental disability or related condition. R8 was not referred to the county offices for person with developmental disabilities or related conditions for evaluation and determination of need for specialized services. During an interview on 1/25/17, at 2:58 p.m. the administrator stated the Level II had not been completed and the county does not have a Level	F 285	R8 was admitted to the facility on 6/9/2016. A level I PASRR was completed by Ucare prior to admission and coded as developmentally disabled, requiring a level II PASRR screening. Ucare sent the referral to St. Louis County Social Services to complete a Level II PASRR screening. St. Louis County social Services failed to complete the screening for level II. St. Louis County Social Services states the resident does not meet the criteria for developmentally disabled and R8 was coded incorrectly by Ucare. St. Louis County Social Services states they have sent the referral to the Minnesota Department of Health for review to determine R8's DD status. 1. the facility reviewed all admissions to identify those residents who meet a level II were screened and the level II screening was received by the facility. 2. The Admissions Director was educated on the process to monitor for completion of level II PASRR screens. 3. The Admission's Director keeps a	

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F 285	Continued From page 7 II on R8. The administrator stated the referral was made, and no one came to do the Level II. On 1/26/17, at 10:49 a.m. the administrator stated it was his responsibility to ensure the Level II was completed. The facility policy Pre-Admission Screening and Resident Review (PASRR) dated 1/17, directed a Level II Screen would be required if the resident is suspected of having a serious mental illness or a developmental disability. The Level II Screen would determine if the resident does have a serious mental illness or developmental disability, as defined by federal regulation, and if so, the resident is appropriate for risking community placement and if the resident needs specialized services or specialized psychiatric rehabilitative services to address his/her disability needs.	F 285	running log to track PASRR. Copies of the PASRR are kept in a file cabinet in the Admissions Director office for acess as well as in the resident chart. 4. The Admission Director will audit all admissions for the necessity of a PASRR and completion weekly for four weeks the monthly for three months. 5. The Executive Direcotr or designee will report audit results and trends of all audits to QA&A committee for review and followup as needed. 5. Completion date: 3/7/17	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 309		3/7/17

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F 309	Continued From page 8 practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate medical equipment was used for a positioning device during IV therapy for 1 of 1 residents (R12) who received IV medications. Findings include: R12's Medical Diagnosis list printed 1/26/17, indicated R12's diagnoses included cellulitis, diabetes mellitus type II, and methicillin resistant staphylococcus aureus infection (an infection caused by an organism resistant to treatment with certain antibiotics-MRSA). R12's Patient Transfer-Interagency Referral Form signed 8/9/16, indicated R12 was discharged form the hospital with left leg cellulitis. The referral form included orders for IV vancomycin (an antibiotic) daily, monitor redness and swelling	F 309	1. R12 did have an IV inserted at the hospital on 8/6/2016 and returned to the facility the same day with an IV in place and orders for Vancomycin IV. The hospital staff reported to the receiving nurse the IV was difficult to start. On 8/13/16 the IV was determined to be poitional due to the pump frequentlyalrming "occluded". The on-call physician requested that the IV be "boarded" with something to secure. The facility dod not have an IV board available. The nurse used a magazine under the arm (not around) and covered the magazine with a washcloth to place between the magazine and the resident's skin. R12 did have redness at the IV insertion site the next day, 8/14/16 at 1755. The nurse was monitoring the site every 15 minutes during the infusion of	

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F 309	Continued From page 9 of left lower extremity, and notified of a positive wound culture with MRSA. R12's physician orders dated 8/10/16, directed R12 to be sent to the emergency room to place an IV for vancomycin administration. R12's physician orders dated 8/15/16, directed staff to discontinue the IV. R12's Medication Administration Record for 8/16, indicated R12 received IV Vancomycin from 8/10/16, through 8/14/16. R12's progress notes dated 8/10/16, indicated R12 had been sent to the hospital to have an IV placed as an outpatient as the IV was not patent (open) to allow for administration of the IV vancomycin. R12's progress note dated 8/13/16, indicated R12's IV had occluded, so was sent to the emergency room to have a new IV placed. The emergency room staff reported it was difficult to place the IV in a good location to ensure it would remain patent. The IV pump was alarming frequently, indicating the IV was occluded (blocked), but the IV would run properly when R12's arm was positioned properly. R12's progress notes indicated the nurses called the doctor who suggested the nurse "board" R12's arm (position it on a medical board to ensure R12's arm remains in the proper position to allow the IV to be administered without occluding). R12's progress notes indicated the nurse rolled up a magazine tightly and splinted R12's arm with it, and used a washcloth underneath to protect his skin. The IV vancomycin was administered without further occlusion. The nurse	F 309	vancomycin. The IV was removed after the vancomycin dose at 2030 and R12 had no complaints of tnderness. R12's wife was sitting at the resident's bedside when the magazine was placed under the arm and stated to the nurse, "oh, if that is what he wants then OK. (referring to the on-call MD)AT least it won't be beeping anymore." The wife did not complain about the incident until 1/24/2017. 2. The nurse involved received education teaching on the use of proper medical equipment for IV therapy. 3. All residents have the potential to be affected by the use of improper medical equipment. the DON/designee will monitor all residents who have IV therapy to ensure that proper medical equipment is used. 4. The facility has obtained IV boards. Nursing staff have been educated on the use of proper medical equipment for IV therapy. 5. Audits for the use of proper IV medical equipment will be completed by the DON or designee weekly for four weeks then monthly for three months. 6. DON or designee will report audit results and trends to QA&A committee for review and followup as needed. 7. Completion date: 3/7/2017	

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F 309	Continued From page 10	F 309		

communicated to the oncoming shift to leave R12's arm splinted with the magazine due to the vulnerability of the IV site.

R12's progress note dated 8/14/16, at 5:55 p.m. indicated R12's IV site had redness with some discomfort upon touch, and was "puffy" but there was no indication of infiltration. R12's progress note indicated the IV was to be discontinued after that dose of vancomycin on 8/14/16.

R12's progress note dated 8/14/16, at 8:33 p.m. indicated R12's IV site was slightly red, and R12 denied tenderness when touched.

On 1/24/17, at 11:55 a.m. family member (FM)-G stated R12 had come from the hospital with an IV, and the hospital did not send an IV board with R12 to the facility. FM-G stated the facility did not have the proper medical equipment to board R12's arm for the IV and used an unsanitary rolled up magazine. FM-G expressed concern with this treatment, as R12 was prone to infections and they were using an unsanitary magazine as an IV board.

On 1/25/17, at 3:01 p.m. the director of nursing (DON) stated the nurse could not find an IV board, so folded a magazine and wrapped it up for use as an IV board. The DON verified the hospital had not sent an IV board with R12 when returning to the facility. The DON verified there would be a risk of contamination or infection when using an unsanitary magazine.

On 1/26/17, at 11:06 a.m. registered nurse (RN)-A stated when she talked to the doctor, he directed her to use a board to brace R12's arm to prevent the IV from occluding. RN-A stated she

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F 309	Continued From page 11 had asked if they could get a board from the hospital and the doctor had asked if there was something else she could use. RN-A stated she had put a washcloth as a barrier between the magazine and R12's arm. RN-A stated she thought the magazine was from R12's room. RN-A verified R12 was prone to infections. At that time, the DON verified R12's IV site was red, puffy, painful, and could indicate an infection. The facility policy and procedure for Intravenous Fluids (IV) dated 4/08, lacked direction for stabilizing or bracing a resident's arm for IV therapy.	F 309		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F 428		3/7/17

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F 428	Continued From page 12 (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to act upon the consulting pharmacists's recommendation for a dose reduction in antidepressant medication for 1 of 5 residents (R39) reviewed for unnecessary medications. Findings include: R39's diagnosis Sheet printed 1/26/17, indicated	F 428	1. On 12/2/2016 the Consultant Pharmacist recommended a GDR of risperdal 1.0 mg BID for agitation. The NP responded "resident still has symptoms/episodes of paranoia, anger. GDR not appropriate at this time." 2. The NP has been educated on the need for an appropriate rationale/justification not to attempt a	

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F 428	Continued From page 13 R39's diagnoses included cardiovascular accident (stroke), hemiparesis (weakness), hemiplegia (paralysis) affecting the right side, anxiety and depression. The significant change Minimum Data Set (MDS) dated 12/29/16, indicated R39 had severe cognitive impairment. R39 had minimal difficulty hearing, was able to make herself understood, and was usually able to understand others. R39 did not have behaviors which included delirium, psychosis and rejection of cares. R39 did not have a change in behavior or other symptoms since the prior assessment. R39 received total to extensive assistance with activities of daily living (ADL), did not have pain, and received antipsychotic, antidepressant and antianxiety medications on seven of seven days during the assessment period. The care plan dated 12/16/16, indicated R39 had a diagnoses of depression. Interventions included; administer medications as ordered, monitor and document side effects and effectiveness. The care plan further directed to monitor, document and report to the nurse signs and symptoms of depression. This included hopelessness, anxiety, sadness, insomnia, anorexia, negative statements, repetitive, anxious or health related complaints, and tearfulness. Pharmacy to review medications monthly or per protocol. Review medications quarterly for appropriateness of gradual dose reduction. The nursing assistant (NA) care sheet dated 1/23/17, indicated R39 had dementia, was resistive to cares at times, had short term memory loss, garbled speech and expressive aphasia.	F 428	GDR when recommended by the Pharmacist. 3. All residents reeiving psychotropic medications have been reviewed for pharmacy recommendations for a GDR. All recommendations that have been denied by MD/NP without an appropriate justification have been resubmitted to the MD/NP for an appropriate justification. 4. The NP has reviewed R39 medications. The NP does not feel a GDR is appropriate for any medications at this time due to continued episodes of paranoia and anger. NP has documented this review. 5. The DON or designee will review pharmacy recommendations monthly with the NP to ensure an appropriate rationale/justification to continue a current dose or to initiate a GDR reduction. 6. Audits for proper justification will be completed by the DON or designee weekly for four weeks then monthly for three months. 7. DON or designee will report audit results and trends of all audits to QA&A commitee for review and follow up as needed. 8. Completion date: 3/7/2017	

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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
F 428	Continued From page 14	F 428		

The Care Area Assessment (CAA) dated 12/29/16, indicated R39 took numerous psychotropic medications including Remeron (antidepressant), Zoloft (antidepressant), Risperdal (antipsychotic) and Buspar (antianxiety). The CAA further directed to see the activities of daily living (ADL) CAA. The ADL CAA indicated R39 was taking medications of remeron, zoloft, risperdal and Buspar all at the family's request related to they felt R39 was having "terrible behaviors" and was "acting crazy." The family had been educated on the risk vs benefit of taking these medications numerous times by the physician, and also had been counciled by staff with little effect. The family still wanted R39 to take the medications. R39 was not exhibiting any adverse side effects. R39 was alert and orientated to self and family.

A Telephone Order (TO) dated and signed by the physician on 9/15/16, indicated orders to increase the Risperdal to 1 milligram (mg) by mouth two times a day. Increase Remeron (an antidepressant) to 30 mg by mouth at bedtime. The TO also included an order for buspirone (also known as Buspar) 7.5 mg by mouth two times a day. The TO lacked indications for use for all of the medications ordered.

The Physician's Medication Review Report dated 1/26/17, indicated R39 received Risperdal 1 mg by mouth two times a day for agitation with a start date of 10/31/16, Remeron 30 mg by mouth at bedtime for agitation with a start date of 10/31/16, Sertraline 100 mg by mouth every day for anxiety with a start date of 4/5/16, and buspirone 7.5 mg by mouth two times a day for anxiety with a start date of 10/31/16.

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A Note to the Attending Physician/Prescriber dated 8/3/16, indicated the consultant pharmacist questioned if a gradual dose reduction (GDR) attempt of the Remeron would be appropriate at that time. The nurse practitioner (NP) responded on 8/25/16, writing, "No GDR of Remeron." The response lacked justification of why or why not to attempt a GDR.

On 1/26/17, at 10:15 a.m. the NP stated R39 was agitated and showing some behaviors, and the Risperdal and the Remeron were increased. The NP further stated the Buspar was added by the physician on 9/15/16. The NP verified there had been no attempts of any GDRs and the response to the consultant pharmacist lacked justification.

On 1/26/17, at 10:40 a.m. the director of nursing (DON) stated R39 had a stroke, and after returning from the hospital she had a change in behavior. The DON verified a GDR had not been attempted since she started in 9/16, and she had informed the NP a reason or rational for the denied response was needed a month or two ago. The DON stated she felt R39 did not have dementia, but has had a change in cognition because of the stroke. The DON further stated R39's behaviors did not disrupt others or her ability to do things, but affected her family and R39's well being.

On 1/26/17, at 3:30 p.m. the consultant pharmacist was interviewed and stated he was new to the facility and had not been to the facility yet. The consultant pharmacist reviewed the previous consultant pharmacist's notes, and verified the notes lacked follow up for justification of why or why not to attempt a GDR for Remeron.

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F 428	Continued From page 16 The facility policy and procedure on Unnecessary Drugs - Psychotropic Drugs revised 11/16, directed for any individual who is receiving any antipsychotic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or increase distressed behavior.	F 428		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is	F 431		3/6/17

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F 431	Continued From page 17 maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were labeled appropriately prior to administration for 1 of 5 residents (R25). Also the facility failed to ensure open vials of medication were labeled with a date the vial was open for 2 of 3 vials of tuberculin and 1 of 2 vials of influenza virus vaccine. Findings include:	F 431	1. medication carts, medication storage room and medication refrigerator have been inspected to ensure all opened medications are dated with an open date and all medication labels match the current order. 2. All nurses have been educated on the proper procedure for medication dose change and label changes as well as the policy to date medications with an open	

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F 431	Continued From page 18 On 1/23/17, at 5:40 p.m. during observation with registered nurse (RN)-B, R25's prescribed trazodone (antidepressant) 100 milligrams (mg) one tablet at bedtime package had hand written on the package in marker half tab only 50 mg. The physician's order on the medication administration record dated January 2017, indicated trazodone 50 mg at bedtime. RN-B stated there should have been a change of direction sticker placed on the trazodone package to alert other staff the directions had changed. On 1/26/17, at 2:27 p.m. during observation with licensed practical nurse (LPN)-B, the medication refrigerator was observed to contain two open vials of tuberculin purified protein derivative diluted (PDD) Aplisol (is used for tuberculin skin testing) one milliliter (ml) with no dates indicating when the vials were open. The sticker on the boxes of tuberculin PDD Aplisol indicated discard after 30 days of being opened with an area to document the date on the sticker (which was left blank). Also observed in medication refrigerator was an open five ml vial of influenza virus vaccine Fluvirin with no date when the vial was opened. LPN-B stated whoever opens the vials should put the date that the vial was opened on the vial. When interviewed on 1/26/17, at 2:42 p.m. the director of nursing (DON) stated open vials of TST and influenza vaccines should be discarded after 30 days after opening. The DON stated staff are to write the date on the vial when the vial was opened. The facility policy Medications-Labeling dated 3/1/14, directed label change stickers should be utilized to identify any medication dose changes until a new pharmacy label is obtained.	F 431	date. 3. Three random audits of the medication label with the medication order will be completed by the DON or designee weekly for four weeks then monthly for three months. 4. Audits of the medication cart, storage room and refrigerator to check for open dates will be completed by the DON or designee weekly for four weeks then monthly for three months. 5. DON or designee will report audit results and trends to QA&A for review and followup as needed. 6. Completion date: 3/6/2017	

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F 431	Continued From page 19 The facility policy Medication Storage in the Facility dated 11/11, directed when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1-The nurse shall place a "date opened" sticker on the medications and enter the date opened and the new date of expiration. The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating.	F 431		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2); (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	F 441		3/6/17

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F 441	Continued From page 20 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. (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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their	F 441		

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F 441	Continued From page 21 program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive infection control program was developed and utilized to include identification of organisms causing infections, tracking and trending, identification of appropriate and effectiveness of treatments. This had the potential to affect all 39 residents residing in the facility. In addition, the facility failed to maintain sanitary storage of clean linens to prevent potential infections. In addition, the facility failed to ensure proper hand hygiene during cares for 1 of 5 residents (R6) observed during personal cares and dressing changes. Finding included: On 1/26/17, at 9:30 a.m. the infection control program was reviewed with the director of nursing (DON), who was the infection control specialist. The DON was responsible for maintaining the infection control log. The DON stated the logs were reviewed at the interdisciplinary team (IDT) meeting and discussed quarterly in quality assurance (QA) meeting. The logs were looked at to determine the infection rate, new antibiotics ordered, and reviewed with medical director. DON verified education on handwashing and gloving was provided during orientation of new staff, and reviewed yearly with all staff, and spot checks were done during cares to ensure compliance. The facility monthly infection control logs were reviewed from March 2016, through January 2017. The logs identified urinary tract infections (UTI) at least monthly. December had four UTI's,	F 441	1. The DON has met with a representative from Infection Control Assessment and Response Program (ICAR) to complete a facility assessment for infection control, review infection control policies, and antibiotic stewardship. The facility is participating in the ICAR program. 2. the DON is documenting all infections on the Infection Control Tracking Log. The log includes the infectious organism, culture date, antibiotic used, re-culture and date resolved. 3. The clean laundry room has been cleaned. All used items from activities and environmental services have been removed from the area. All clean laundry is stored separately from dirty laundry. 4. All staff have been educated on the correct procedure for proper handwashing and gloving. 5. DON or designee will audit the Infection Control Tracking Log to ensure it is completed fully weekly for four weeks then monthly for three months. 6. Environmental Services Director will audit the laundry room for cleanliness, proper storage of laundry weekly for four weeks then monthly for three months. 7. Three random audits for proper	

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F 441	Continued From page 22 November had three UTI's, July, June, May, April, March, and January had two UTI's each month, and August, September, October each had one UTI identified each month. The columns for Culture, Organism, Recultered and Date Resolved on the infection control logs were blank from March 2016, through January 2017. The DON stated the UTI's had been discussed with the IDT. The staff was pushing fluids, and she would be starting a new antibiotic stewardship program soon. The DON verified the logs lacked information for the identification of infectious organisms, and the ability to track and trend infections in the facility. The DON verified that education on handwashing and gloving was provided during orientation of new staff and reviewed yearly with all staff, and spot checks are done during cares to ensure compliance. The facility Infection Prevention and Control policy dated 11/8/16, directed a system is to be in place that prevents, identifies, reports, investigates and controls infections and communicable diseases. The facility failed to maintain sanitary storage of clean linens to prevent potential infections. On 1/26/17, at 10:00 a.m. the clean laundry room was observed with laundry director (LD)-D. The laundry room was T-shaped. The long area of the room had some shelving along the wall containing boxes and miscellaneous items. There was a rack of uncovered clean clothes a few feet away from shelving, three televisions on a cart, and three dirty vacuum cleaners near by. In the middle section of the room there was a chair in	F 441	handwashing and gloving will be completed by the DON or designee weekly for four weeks then monthly for three months. 8. DON or designee and Environmental Services Director will report audit results and trends of all audits to QA&A committee for review and followup as needed. 9. Completion date: 3/6/2017	

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F 441	Continued From page 23 the corner, with clothing piled on the seat, and three shirts laying on the floor in front of chair. There was shelving holding clean linen, and overloaded bins holding towels and wash cloths. LD-D verified the clothing on the floor, and stated the clothes were from a deceased resident. LD-D stated the facility had run out of places to put things, so activities and housekeeping had been storing items in the clean laundry room. On 1/26/17, at 11:55 a.m. the administrator was interviewed and stated space was limited. The administrator stated other departments have been keeping items in the clean laundry area. The administrator further stated it would be an expectation that the area be divided up so each department has an area away from the clean laundry. The facility policy Linens-Handling dated 3/1/14, directed when handling, storing, processing, and transporting linens, facility personnel use procedures designed to prevent the spread of infection. R6's quarterly Minimum Data Set (MDS) dated 1/13/17, indicated R6 had moderately impaired cognition and required extensive assistance of one staff with transfers and toilet use. R6 was frequently incontinent of bladder. On 1/25/17, at 8:55 a.m. R6 was observed during toileting with nursing assistant (NA)-A. NA-A did not wash her hands prior to donning gloves. NA-A applied the transfer belt to R6, assisted R6 to	F 441		

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F 441	Continued From page 24 stand and turn, lowered R6's pants and incontinent product, and assisted R6 to sit on the toilet. NA-A removed her gloves and washed her hands. At 9:07 a.m. NA-A assisted R6 with a transfer off of the toilet. NA-A did not wash her hands prior to donning gloves. NA-A wiped R6's buttocks with a wet wipe, removed the gloves and donned new gloves. NA-A did not wash or sanitize her hands when the gloves were changed. R6 stood using the transfer bar and waited for NA-A to pull up his incontinent product and pants. After assisting R6 to turn and sit in the wheelchair, NA-A then washed her hands. On 1/25/17, at 9:15 a.m. NA-A stated that was the the way she usually assisted R6. NA-A verified she did not wash or sanitize her hands prior to applying the gloves, after she cleaned R6 after having a bowel movement and when she removed her gloves and applied new gloves. NA-A further stated she washed her hands often and washed her hands in the utility room when exiting the utility room. NA-A stated she quickly changes her gloves between dirty and clean without washing or sanitizing because R6 will turn and sit before she was ready. The facility's Hand Washing policy dated 4/1/08, indicated the facility required staff to wash their hands after direct contact for which hand washing was indicated by accepted profession practice and the CDC (Center for Disease Control) guidelines.	F 441		
F 465 SS=B	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions	F 465		3/7/17

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F 465	Continued From page 25 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a homelike, safe and sanitary environment was maintained in 3 of 30 resident rooms (203, 210, 321) observed for environment. Findings include: On 1/26/17, at 11:00 a.m. during an environmental tour the maintenance supervisor (MS) verified the following environmental findings: Room 203, the wall at the head of the bed, and the side of the bed at the siderail, had several scraped areas exposing the sheet rock. In addition, the wall near the siderail had four to five small holes. Room 210, the bottom corner of the closet on the sink side was broken off causing a rough surface. The molding along the bottom of the closet was pulled away, and the end of the molding was broken and sharp. Room 321, the walls at the head of the bed, and behind the recliner were scraped exposing the sheet rock.	F 465	1. Maintenance has repaired the walls in room 203 and 321, and closet and molding in room 210. 2. Environmental Services Director will complete weekly Environmental Service rounds to ensure homelike, safe, and sanitary environment is maintained. Any issues noted during the walk through will be referred to the maintenance department for repair. 3. All staff have been educated on the process for reporting any damage to equipment, to the environment, etc. to their supervisor for placing a maintenance order for repair. 4. Environmental Services Director will report audit results and trends to QA&A for review and followup as needed. 5. Completion date: 3/7/2017	

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F 465	Continued From page 26 During the environmental tour the MS stated in room 203 the wall protector was missing and should be there. The same as in the other resident rooms. The MS further stated the facility had a computer system to notify maintenance of any repairs needed, all management and nurses had the ability to use it. The MS further stated it was just a matter of educating staff of what and how to report. The MS stated he would expect staff to report repairs needed in resident rooms. The MS further stated he does a walk through the facility daily, but does not go into the resident rooms except weekly when the water temperature was checked in one resident room on each hall. The facility's Physical Environment-Resident Room policy dated 4/1/08, indicated resident rooms were designed and equipped for adequate nursing care, comfort and privacy.	F 465		

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

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	245138	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/25/2017**

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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Boundary Waters Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 has a fire alarm system with smoke detection throughout the corridor system and in the common spaces. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 42 beds and had a census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 13, 2017

Mr. Adam Masloski, Administrator
Boundary Waters Care Center
200 West Conan Street
Ely, Minnesota 55731

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5138027, H5138016

Dear Mr. Masloski:

The above facility was surveyed on January 23, 2017 through January 26, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5138016. that was found to be substantiated at MN Rule 4658.0520 Subp.1 (0830). At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the

Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Teresa Ament at: (218) 302-6151 or email: teresa.ament@state.mn.us**.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00587	A. BUILDING: _____ B. WING _____	C 01/26/2017

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 1/23/17, through 1/26/17, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Investigation of complaint H5138016 was completed. The complaint was substantiated at MN Rule 4658.0520 Subp. 1 (0830).	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention;	2 265		2/16/17

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2 265	Continued From page 2 B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a family representative was informed of a change in treatment for 1 of 3 residents (R12) interviewed for notification of change in status. Findings include: On 1/24/17, at 12:01 p.m. family member (FM)-G stated the family was not informed that oxygen therapy was initiated for R12. R12's Medical Diagnosis list printed 1/26/17, indicated R12's diagnoses included other nonspecific abnormal finding of lung field and atrial fibrillation (irregular heart beat). R12's Medication Review Report dated 1/26/17, indicated R12 had a physician's order received 1/20/17, for oxygen at 2 liters per minute (LPM)	2 265	Corrected	

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2 265	Continued From page 3 via nasal cannula every shift for low oxygen saturation due to a tumor. R12's Treatment Administration Record (TAR) for 1/17, indicated oxygen therapy was initiated during the day shift on 1/17/17, to keep oxygen saturations greater than 90%. The TAR indicated the oxygen order was changed to the physician's order on 1/20/17. R12's Progress Notes dated 1/10/17, indicated R12's oxygen saturations were 92% on oxygen at 1 LPM per nasal cannula. R12's Progress Notes dated 1/13/17 and 1/15/17, indicated R12 continued with oxygen therapy. R12's Progress Notes lacked documentation regarding notification of R12's family regarding the start of oxygen therapy, but indicated R12's family was in to visit on 1/15/17. On 1/25/17, at 7:00 a.m. R12 was observed sitting in a reclining chair near the nurse's station with oxygen on per nasal cannula. On 1/25/17, at 2:59 p.m. the director of nursing (DON) verified family members were to be notified of a resident's change in condition and treatments, and the notification should be documented in the progress notes. On 1/26/17, at 11:01 a.m. the DON further verified R12's progress notes did not indicate the family had been notified of the change in status when the oxygen therapy was initiated. The DON stated she would expect the family would be notified and the notification to be documented in the progress notes. The facility policy and procedure for Notification to Physician/Family/Resident Representative of	2 265		

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2 265	Continued From page 4 Change in Resident Health Status revised 11/16, directed staff to notify the resident representative or interested family when there is an acute illness or a significant change in the resident's physical status, such as a deterioration in health , or if there is a need to alter treatment significantly. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents/family representatives/physicians are notified of a change in condition or treatment. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include:	2 302		3/6/17

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2 302	Continued From page 5 (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided information regarding the facility's Alzheimer's training for staff. Findings include: During an interview on 1/26/17, at 12:15 p.m. with the administrator stated the facility does not provide any information to the consumers regarding the training of staff on Alzheimer's disease. A facility policy was requested and none was provided. SUGGESTED METHOD OF CORRECTION: The administrator could review and revise facility policies and procedures related to Alzheimer's training and information provided to consumers. Responsible personnel could be re-educated on these policies and procedures. Appropriate	2 302	Corrected	

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2 302	Continued From page 6 efforts could be made toward informing consumers of Alzheimer's training provided to employees. A documentation and monitoring system could be developed and implemented to ensure consumers have been informed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 302		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate medical equipment was used for a positioning device during IV therapy for 1 of 1 residents (R12) who received IV medications. Findings include: R12's Medical Diagnosis list printed 1/26/17, indicated R12's diagnoses included cellulitis,	2 830	Corrected	3/6/17

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2 830	Continued From page 7 diabetes mellitus type II, and methicillin resistant staphylococcus aureus infection (an infection caused by an organism resistant to treatment with certain antibiotics-MRSA). R12's Patient Transfer-Interagency Referral Form signed 8/9/16, indicated R12 was discharged form the hospital with left leg cellulitis. The referral form included orders for IV vancomycin (an antibiotic) daily, monitor redness and swelling of left lower extremity, and notified of a positive wound culture with MRSA. R12's physician orders dated 8/10/16, directed R12 to be sent to the emergency room to place an IV for vancomycin administration. R12's physician orders dated 8/15/16, directed staff to discontinue the IV. R12's Medication Administration Record for 8/16, indicated R12 received IV Vancomycin from 8/10/16, through 8/14/16. R12's progress notes dated 8/10/16, indicated R12 had been sent to the hospital to have an IV placed as an outpatient as the IV was not patent (open) to allow for administration of the IV vancomycin. R12's progress note dated 8/13/16, indicated R12's IV had occluded, so was sent to the emergency room to have a new IV placed. The emergency room staff reported it was difficult to place the IV in a good location to ensure it would remain patent. The IV pump was alarming frequently, indicating the IV was occluded (blocked), but the IV would run properly when R12's arm was positioned properly. R12's progress notes indicated the nurses called the	2 830		

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2 830	Continued From page 8	2 830		

doctor who suggested the nurse "board" R12's arm (position it on a medical board to ensure R12's arm remains in the proper position to allow the IV to be administered without occluding). R12's progress notes indicated the nurse rolled up a magazine tightly and splinted R12's arm with it, and used a washcloth underneath to protect his skin. The IV vancomycin was administered without further occlusion. The nurse communicated to the oncoming shift to leave R12's arm splinted with the magazine due to the vulnerability of the IV site.

R12's progress note dated 8/14/16, at 5:55 p.m. indicated R12's IV site had redness with some discomfort upon touch, and was "puffy" but there was no indication of infiltration. R12's progress note indicated the IV was to be discontinued after that dose of vancomycin on 8/14/16.

R12's progress note dated 8/14/16, at 8:33 p.m. indicated R12's IV site was slightly red, and R12 denied tenderness when touched.

On 1/24/17, at 11:55 a.m. family member (FM)-G stated R12 had come from the hospital with an IV, and the hospital did not send an IV board with R12 to the facility. FM-G stated the facility did not have the proper medical equipment to board R12's arm for the IV and used an unsanitary rolled up magazine. FM-G expressed concern with this treatment, as R12 was prone to infections and they were using an unsanitary magazine as an IV board.

On 1/25/17, at 3:01 p.m. the director of nursing (DON) stated the nurse could not find an IV board, so folded a magazine and wrapped it up for use as an IV board. The DON verified the hospital had not sent an IV board with R12 when

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2 830	Continued From page 9 returning to the facility. The DON verified there would be a risk of contamination or infection when using an unsanitary magazine. On 1/26/17, at 11:06 a.m. registered nurse (RN)-A stated when she talked to the doctor, he directed her to use a board to brace R12's arm to prevent the IV from occluding. RN-A stated she had asked if they could get a board from the hospital and the doctor had asked if there was something else she could use. RN-A stated she had put a washcloth as a barrier between the magazine and R12's arm. RN-A stated she thought the magazine was from R12's room. RN-A verified R12 was prone to infections. At that time, the DON verified R12's IV site was red, puffy, painful, and could indicate an infection. The facility policy and procedure for Intravenous Fluids (IV) dated 4/08, lacked direction for stabilizing or bracing a resident's arm for IV therapy. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure proper medical equipment is obtained and used for medical treatments. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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21375	Continued From page 10	21375		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive infection control program was developed and utilized to include identification of organisms causing infections, tracking and trending, identification of appropriate and effectiveness of treatments. This had the potential to affect all 39 residents residing in the facility. In addition, the facility failed to maintain sanitary storage of clean linens to prevent potential infections. In addition, the facility failed to ensure proper hand hygiene during cares for 1 of 5 residents (R6) observed during personal cares and dressing changes. Finding included: On 1/26/17, at 9:30 a.m. the infection control program was reviewed with the director of nursing (DON), who was the infection control specialist. The DON was responsible for maintaining the infection control log. The DON stated the logs were reviewed at the interdisciplinary team (IDT) meeting and discussed quarterly in quality assurance (QA) meeting. The logs were looked at to determine the infection rate, new antibiotics ordered, and reviewed with medical director. DON verified education on handwashing and gloving was provided during orientation of new	21375	Corrected	3/6/17

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21375	Continued From page 11 staff, and reviewed yearly with all staff, and spot checks were done during cares to ensure compliance. The facility monthly infection control logs were reviewed from March 2016, through January 2017. The logs identified urinary tract infections (UTI) at least monthly. December had four UTI's, November had three UTI's, July, June, May, April, March, and January had two UTI's each month, and August, September, October each had one UTI identified each month. The columns for Culture, Organism, Recultered and Date Resolved on the infection control logs were blank from March 2016, through January 2017. The DON stated the UTI's had been discussed with the IDT. The staff was pushing fluids, and she would be starting a new antibiotic stewardship program soon. The DON verified the logs lacked information for the identification of infectious organisms, and the ability to track and trend infections in the facility. The DON verified that education on handwashing and gloving was provided during orientation of new staff and reviewed yearly with all staff, and spot checks are done during cares to ensure compliance. The facility Infection Prevention and Control policy dated 11/8/16, directed a system is to be in place that prevents, identifies, reports, investigates and controls infections and communicable diseases. The facility failed to maintain sanitary storage of clean linens to prevent potential infections. On 1/26/17, at 10:00 a.m. the clean laundry room was observed with laundry director (LD)-D. The	21375		

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laundry room was T-shaped. The long area of the room had some shelving along the wall containing boxes and miscellaneous items. There was a rack of uncovered clean clothes a few feet away from shelving, three televisions on a cart, and three dirty vacuum cleaners near by. In the middle section of the room there was a chair in the corner, with clothing piled on the seat, and three shirts laying on the floor in front of chair. There was shelving holding clean linen, and overloaded bins holding towels and wash cloths. LD-D verified the clothing on the floor, and stated the clothes were from a deceased resident. LD-D stated the facility had run out of places to put things, so activities and housekeeping had been storing items in the clean laundry room.

On 1/26/17, at 11:55 a.m. the administrator was interviewed and stated space was limited. The administrator stated other departments have been keeping items in the clean laundry area. The administrator further stated it would be an expectation that the area be divided up so each department has an area away from the clean laundry.

The facility policy Linens-Handling dated 3/1/14, directed when handling, storing, processing, and transporting linens, facility personnel use procedures designed to prevent the spread of infection.

R6's quarterly Minimum Data Set (MDS) dated 1/13/17, indicated R6 had moderately impaired cognition and required extensive assistance of one staff with transfers and toilet use. R6 was frequently incontinent of bladder.

On 1/25/17, at 8:55 a.m. R6 was observed during toileting with nursing assistant (NA)-A. NA-A did

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not wash her hands prior to donning gloves. NA-A applied the transfer belt to R6, assisted R6 to stand and turn, lowered R6's pants and incontinent product, and assisted R6 to sit on the toilet. NA-A removed her gloves and washed her hands. At 9:07 a.m. NA-A assisted R6 with a transfer off of the toilet. NA-A did not wash her hands prior to donning gloves. NA-A wiped R6's buttocks with a wet wipe, removed the gloves and donned new gloves. NA-A did not wash or sanitize her hands when the gloves were changed. R6 stood using the transfer bar and waited for NA-A to pull up his incontinent product and pants. After assisting R6 to turn and sit in the wheelchair, NA-A then washed her hands.

On 1/25/17, at 9:15 a.m. NA-A stated that was the the way she usually assisted R6. NA-A verified she did not wash or sanitize her hands prior to applying the gloves, after she cleaned R6 after having a bowel movement and when she removed her gloves and applied new gloves. NA-A further stated she washed her hands often and washed her hands in the utility room when exiting the utility room. NA-A stated she quickly changes her gloves between dirty and clean without washing or sanitizing because R6 will turn and sit before she was ready.

The facility's Hand Washing policy dated 4/1/08, indicated the facility required staff to wash their hands after direct contact for which hand washing was indicated by accepted profession practice and the CDC (Center for Disease Control) guidelines.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designee could develop and implement systems and policies and procedures to ensure a comprehensive infection

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21375	Continued From page 14 control program includes tracking and trending of infections, proper hand hygiene during cares, and sanitary storage of linens. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced	21426		3/6/17

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21426	Continued From page 15 by: Based on interview and documentation review, the facility failed to ensure baseline tuberculosis (TB) symptom and history screening were performed for 1 of 5 employees (NA)-E reviewed for TB screening. Findings include: NA-E was hired on 9/1/16. The baseline TB symptom and history screening was completed on 10/17/16, which was 46 days after actively working in the facility. On 1/26/17, at 9:30 a.m. the director of nursing (DON) was interviewed and stated all employees receive a TB screening, 2 step Mantoux (a screening test for TB), or chest x-ray upon hire, and the first step Mantoux is read before they start working in the facility. On 1/26/17, at 1:00 p.m. the DON verified NA-E was actively working in the facility, and the TB screening was missed at the time of hire, and completed on 10/17/16. The facility's Tuberculosis Testing of Healthcare Workers undated, indicated all healthcare workers would be tested for TB upon hire. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and the two step Mantoux process. The DON and/or designee could develop a monitoring system to ensure ongoing compliance.	21426	Corrected	

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21426	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to act upon the consulting pharmacists's recommendation for a dose reduction in antidepressant medication for 1 of 5 residents (R39) reviewed for unnecessary medications.	21540	Corrected	3/6/17

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21540	Continued From page 17 Findings include: R39's diagnosis Sheet printed 1/26/17, indicated R39's diagnoses included cardiovascular accident (stroke), hemiparesis (weakness), hemiplegia (paralysis) affecting the right side, anxiety and depression. The significant change Minimum Data Set (MDS) dated 12/29/16, indicated R39 had severe cognitive impairment. R39 had minimal difficulty hearing, was able to make herself understood, and was usually able to understand others. R39 did not have behaviors which included delirium, psychosis and rejection of cares. R39 did not have a change in behavior or other symptoms since the prior assessment. R39 received total to extensive assistance with activities of daily living (ADL), did not have pain, and received antipsychotic, antidepressant and antianxiety medications on seven of seven days during the assessment period. The care plan dated 12/16/16, indicated R39 had a diagnoses of depression. Interventions included; administer medications as ordered, monitor and document side effects and effectiveness. The care plan further directed to monitor, document and report to the nurse signs and symptoms of depression. This included hopelessness, anxiety, sadness, insomnia, anorexia, negative statements, repetitive, anxious or health related complaints, and tearfulness. Pharmacy to review medications monthly or per protocol. Review medications quarterly for appropriateness of gradual dose reduction. The nursing assistant (NA) care sheet dated 1/23/17, indicated R39 had dementia, was resistive to cares at times, had short term	21540		

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21540	Continued From page 18 memory loss, garbled speech and expressive aphasia. The Care Area Assessment (CAA) dated 12/29/16, indicated R39 took numerous psychotropic medications including Remeron (antidepressant), Zoloft (antidepressant), Risperdal (antipsychotic) and Buspar (antianxiety). The CAA further directed to see the activities of daily living (ADL) CAA. The ADL CAA indicated R39 was taking medications of remeron, zoloft, risperdal and Buspar all at the family's request related to they felt R39 was having "terrible behaviors" and was "acting crazy." The family had been educated on the risk vs benefit of taking these medications numerous times by the physician, and also had been counciled by staff with little effect. The family still wanted R39 to take the medications. R39 was not exhibiting any adverse side effects. R39 was alert and orientated to self and family. A Telephone Order (TO) dated and signed by the physician on 9/15/16, indicated orders to increase the Risperdal to 1 milligram (mg) by mouth two times a day. Increase Remeron (an antidepressant) to 30 mg by mouth at bedtime. The TO also included an order for buspirone (also known as Buspar) 7.5 mg by mouth two times a day. The TO lacked indications for use for all of the medications ordered. The Physician's Medication Review Report dated 1/26/17, indicated R39 received Risperdal 1 mg by mouth two times a day for agitation with a start date of 10/31/16, Remeron 30 mg by mouth at bedtime for agitation with a start date of 10/31/16, Sertraline 100 mg by mouth every day for anxiety with a start date of 4/5/16, and buspirone 7.5 mg by mouth two times a day for anxiety with a start	21540		

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21540	Continued From page 19 date of 10/31/16. A Note to the Attending Physician/Prescriber dated 8/3/16, indicated the consultant pharmacist questioned if a gradual dose reduction (GDR) attempt of the Remeron would be appropriate at that time. The nurse practitioner (NP) responded on 8/25/16, writing, "No GDR of Remeron." The response lacked justification of why or why not to attempt a GDR. On 1/26/17, at 10:15 a.m. the NP stated R39 was agitated and showing some behaviors, and the Risperdal and the Remeron were increased. The NP further stated the Buspar was added by the physician on 9/15/16. The NP verified there had been no attempts of any GDRs and the response to the consultant pharmacist lacked justification. On 1/26/17, at 10:40 a.m. the director of nursing (DON) stated R39 had a stroke, and after returning from the hospital she had a change in behavior. The DON verified a GDR had not been attempted since she started in 9/16, and she had informed the NP a reason or rational for the denied response was needed a month or two ago. The DON stated she felt R39 did not have dementia, but has had a change in cognition because of the stroke. The DON further stated R39's behaviors did not disrupt others or her ability to do things, but affected her family and R39's well being. On 1/26/17, at 3:30 p.m. the consultant pharmacist was interviewed and stated he was new to the facility and had not been to the facility yet. The consultant pharmacist reviewed the previous consultant pharmacist's notes, and verified the notes lacked follow up for justification of why or why not to attempt a GDR for Remeron.	21540		

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21540	Continued From page 20 The facility policy and procedure on Unnecessary Drugs - Psychotropic Drugs revised 11/16, directed for any individual who is receiving any antipsychotic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or increase distressed behavior. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or pharmacist could in-service all staff responsible for medication use on the need to meet the requirements for addressing and following up on pharmacist recommendations as written in this licensing order. The DON or designee, or pharmacist could educate all appropriate staff on the policies and procedures. The DON or designee and pharmacist could develop mitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications	21620	Corrected	3/6/17

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21620	Continued From page 21 were labeled appropriately prior to administration for 1 of 5 residents (R25). Also the facility failed to ensure open vials of medication were labeled with a date the vial was open for 2 of 3 vials of tuberculin and 1 of 2 vials of influenza virus vaccine. Findings include: On 1/23/17, at 5:40 p.m. during observation with registered nurse (RN)-B, R25's prescribed trazodone (antidepressant) 100 milligrams (mg) one tablet at bedtime package had hand written on the package in marker half tab only 50 mg. The physician's order on the medication administration record dated January 2017, indicated trazodone 50 mg at bedtime. RN-B stated there should have been a change of direction sticker placed on the trazodone package to alert other staff the directions had changed. On 1/26/17, at 2:27 p.m. during observation with licensed practical nurse (LPN)-B, the medication refrigerator was observed to contain two open vials of tuberculin purified protein derivative diluted (PDD) Aplisol (is used for tuberculin skin testing) one milliliter (ml) with no dates indicating when the vials were open. The sticker on the boxes of tuberculin PDD Aplisol indicated discard after 30 days of being opened with an area to document the date on the sticker (which was left blank). Also observed in medication refrigerator was an open five ml vial of influenza virus vaccine Fluvirin with no date when the vial was opened. LPN-B stated whoever opens the vials should put the date that the vial was opened on the vial. When interviewed on 1/26/17, at 2:42 p.m. the director of nursing (DON) stated open vials of TST and influenza vaccines should be discarded	21620		

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21620	Continued From page 22 after 30 days after opening. The DON stated staff are to write the date on the vial when the vial was opened. The facility policy Medications-Labeling dated 3/1/14, directed label change stickers should be utilized to identify any medication dose changes until a new pharmacy label is obtained. The facility policy Medication Storage in the Facility dated 11/11, directed when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1-The nurse shall place a "date opened" sticker on the medications and enter the date opened and the new date of expiration. The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage and labeling of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical	21665		3/6/17

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21665	Continued From page 23 environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a homelike, safe and sanitary environment was maintained in 3 of 30 resident rooms (203, 210, 321) observed for environment. Findings include: On 1/26/17, at 11:00 a.m. during an environmental tour the maintenance supervisor (MS) verified the following environmental findings: Room 203, the wall at the head of the bed, and the side of the bed at the siderail, had several scraped areas exposing the sheet rock. In addition, the wall near the siderail had four to five small holes. Room 210, the bottom corner of the closet on the sink side was broken off causing a rough surface. The molding along the bottom of the closet was pulled away, and the end of the molding was broken and sharp. Room 321, the walls at the head of the bed, and behind the recliner were scraped exposing the sheet rock. During the environmental tour the MS stated in room 203 the wall protector was missing and should be there. The same as in the other resident rooms. The MS further stated the facility had a computer system to notify maintenance of any repairs needed, all management and nurses	21665	Corrected	

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21665	Continued From page 24 had the ability to use it. The MS further stated it was just a matter of educating staff of what and how to report. The MS stated he would expect staff to report repairs needed in resident rooms. The MS further stated he does a walk through the facility daily, but does not go into the resident rooms except weekly when the water temperature was checked in one resident room on each hall. The facility's Physical Environment-Resident Room policy dated 4/1/08, indicated resident rooms were designed and equipped for adequate nursing care, comfort and privacy. SUGGESTED METHOD OF CORRECTION: The environmental services director could develop and implement systems to ensure the environment is safe, clean, functional and homelike. The environmental services director could educate all appropriate staff. The environmental services director could monitor this process to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		