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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9G8I

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00587

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

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

6. DATE OF SURVEY **02/08/2018** (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:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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):

17. SURVEYOR SIGNATURE Date:
Terri Ament, Unit Supervisor 02/28/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 05/29/2018 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/16/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245138 February 28, 2018

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.

Effective February 7, 2018 the above facility is 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 any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 28, 2018

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

RE: Project Number S5138028

Dear Mr. Masloski:

On December 29, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 14, 2017.. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 8, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 8, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 14, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 7, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 14, 2017, effective February 7, 2018 and therefore remedies outlined in our letter to you dated December 29, 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.

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9G8I

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(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 **12/14/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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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):

17. SURVEYOR SIGNATURE Date :
Maria Reyes, HFE NE II 01/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/16/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
07/24/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 29, 2017

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

RE: Project Number S5138028

Dear Mr. Masloski:

On December 14, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
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 January 23, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 23, 2018 the following remedy will be imposed:

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

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.

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 March 14, 2018 (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 June 14, 2018 (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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245138	A. BUILDING _____ B. WING _____	12/14/2017

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 A recertification survey was conducted December 11 through December 14, 2017 by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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	F 000		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly	F 568		2/7/18

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

Electronically Signed | 01/06/2018

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.

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 _____	12/14/2017

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 568	Continued From page 1 statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a financial statement to 1 of 2 residents (R24) who had requested to receive a quarterly statement of their personal funds account. Findings include: R24's quarterly Minimum Data Set (MDS) dated 11/6/17, indicated he had moderately impaired cognition. On 12/11/17, at 3:23 p.m. R24 was interviewed and stated he had requested to receive a quarterly financial statement of his personal funds account, but had not received one. On 12/14/17, at 8:27 a.m. the facilities business office director (BD)-A was interviewed and stated she would ask residents upon admission if they wanted to receive a statement of their personal funds account balance. BD-A stated R24 had a personal funds account, and he frequently accessed it. BD-A stated a quarterly statement was automatically sent to a resident's power of attorney (POA). R24's quarterly statement went to his POA. BD-A stated there was an area on the form to indicate if a resident wanted to get a statement as well. BD-A stated R24 did indicate that he wanted to receive a statement, but she did not have that set up for him. BD-A stated she should have set it up for R24 to receive a statement. R24's undated Resident Trust Account Management Agreement indicated R24 would	F 568	1.Resident 24 had file updated to generate a financial statement for the resident in addition to the Power of Attorney. 2.All current Resident files will be audited to ensure accuracy of the financial statement setup in PointClickCare. 3.Policy has been updated to provide direction on providing financial statements to Residents. 4.All new admissions will be audited weekly for one month and then monthly for three months. 5.Audits will be reviewed at Quality Assurance meetings on a monthly basis. 6.It is the responsibility of the Executive Director/Business Office Director to ensure compliance.	

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 _____	12/14/2017

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 568	Continued From page 2 receive a copy of the quarterly statement of the account. The facility's Resident Trust Account policy dated 1/13, directed every resident has the right to manage his or her financial affairs. The policy lacked direction on providing statements to residents.	F 568		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable	F 583		2/7/18

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F 583	Continued From page 3 federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a urinary catheter bag was not visible to passersby, and a Hospice sticker was not visible on a medical chart for 1 of 1 resident (R24) reviewed for privacy. Findings include: R24's Face Sheet printed 12/13/17, indicated R24 was on hospice, and had diagnoses that included chronic obstructive pulmonary disease (COPD). R24's quarterly Minimum Data Set (MDS) dated 11/6/17, indicated R24 had moderate cognitive impairment, and had an indwelling urinary catheter. The MDS also indicated R24 had a prognosis of life expectancy of less than 6 months. On 12/11/17, at 6:17 p.m. R24's medical chart was visible at the nurse's station. R24's medical chart had his name on it, and there was a green Hospice sticker above his name. R24 was then observed from the hallway. R24 was in bed, and his urinary catheter bag was hanging off the side of his bed. The urinary catheter bag was uncovered, contained urine, and was visible to anyone glancing into his room. On 12/13/17, at 9:02 a.m. R24's medical chart	F 583	1.Resident 24's Foley catheter bag was covered with a dignity bag when found to be visible to the public/staff, the Hospice sticker was moved to the top of the charts immediately and was no longer visible. 2.Nursing staff were educated to protection of privacy in relation to hospice care during staff meetings. Nursing staff educated on catheter dignity bags. 3.All other Hospice residents' charts were reviewed and the sticker moved. 4.No other residents at this time have a Foley catheter. 5.All new admissions requiring one will be provided catheter dignity bags. 6.Audits will be conducted 2x a week for a month, 1x a week for a month then monthly for three months. 7.Audits will be reviewed at monthly QA meetings. 8.It is the responsibility of the Director of Nursing or Designee to ensure compliance.	

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F 583	Continued From page 4 remained visible at the nurse's station. The green Hospice sticker remained above R24's name. R24 was then observed from the hallway. R24 was in bed, and his urinary catheter bag was hanging off the side of his bed. The urinary catheter bag was uncovered, contained urine, and was visible to anyone glancing into his room. On 12/14/17, at 8:34 a.m. R24's medical chart remained visible at the nurse's station. The green Hospice sticker remained above R24's name. R24 was then observed from the hallway. R24 was in bed, and his urinary catheter bag was hanging off the side of his bed. The urinary catheter bag was uncovered, contained urine, and was visible to anyone glancing into his room. On 12/14/17, at 9:15 a.m. the director of nursing (DON) was interviewed. The DON verified R24's uncovered catheter bag was visible to anyone passing by and looking into R24's room. The DON verified this was a privacy issue, and stated there were catheter bag covers for staff to use. The DON also verified the green Hospice sticker on R24's chart, stating the sticker would alert anyone at the nurse's station to know R24 was on Hospice. The facility was unable to provide a policy on resident privacy.	F 583		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		2/7/18

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F 641	Continued From page 5 Based on observation, interview, and document review, the facility failed to accurately code the MDS for 12 of 12 residents (R21, R24, R29, R16, R32, R27, R33, R30, R31, R17, R191, and R37) reviewed for accuracy of the MDS. Findings include: R21's quarterly Minimum Data Set (MDS) dated 10/26/17, indicated R21 used side rails daily as a restraint, and required extensive assistance of two staff with bed mobility and transfers. On 12/12/17, at 9:42 a.m. R21's bed was observed with bilateral upper side rails. R24's quarterly MDS dated 11/6/17, indicated R24 used side rails daily as a restraint, and required extensive assistance of two staff with bed mobility and transfers. On 12/11/17, at 5:53 p.m. R24's bed was observed with bilateral upper side rails. R29's quarterly MDS dated 11/15/17, indicated R29 used side rails daily as a restraint, and required extensive assistance of two staff with bed mobility and transfers. On 12/11/17, at 2:48 p.m. R29's bed was observed with bilateral upper side rails. On 12/13/17, at 11:13 a.m. registered nurse (RN)-A was interviewed. RN-A stated she was the nurse responsible for completing all resident's MDS. RN-A stated she thought she had coded only that the residents used side rails, and didn't realize she had coded the side rails as a restraint. RN-A stated she had coded all residents in the	F 641	1.Modification was done for the MDS correcting side rail restraint use response to “no” for question P0100, letter a, for residents 17, 21, 37, 24, 19, 30, 31, 29, 16, 32, 27 and 33. 2.RN MDS Coordinator was re-educated with review of RAI manual regarding the intent and proper way to code this item on the MDS and verbalized understanding of how to code this item going forward. 3.Education provided to D.O.N, nurse manager, and MDS back-up RN on completion of question P0100, letter a. 4.Facility will audit the MDS going back one quarter from January 4th 2018 for all current residents who use side rails as a mobility aid, then will continue weekly for 1 month, then monthly for 3 months. 5.Audits will be reviewed at monthly QA meetings. 6.It is the responsibility of the DON/MDS coordinator to ensure compliance with correct coding of the MDS.	

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F 641	Continued From page 6	F 641		

facility that use side rails as having a restraint. RN-A verified all residents who utilized side rails had an incorrectly coded MDS. RN-A further stated the facility had no restraints.

The facility policy Nursing Documentation (General) dated 4/09, directed the MDS be completed per Centers for Medicare Services (CMS) and Medicare guidelines.

R16's quarterly Minimum Data Set (MDS) dated 10/10/17, indicated R16 used side rails daily as a restraint, and was independent with bed mobility and independent with transfers.

On 12/12/17, at 9:24 a.m. R16's bed was observed with bilateral upper side rails.

R32's annual MDS dated 11/13/17, indicated R32 used side rails daily as a restraint, and required total assistance of two staff for bed mobility and transfers.

On 12/12/17, at 10:34 a.m. R32's bed was observed bilateral upper side rails.

R27's annual MDS dated 11/13/17, indicated R32 used side rails daily as a restraint, and required extensive assistance of one staff for bed mobility, and extensive assistance of two staff for transfers.

On 12/12/17, at 9:38 a.m. R27's bed was observed with bilateral upper side rails.

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F 641	Continued From page 7	F 641		

R33's quarterly Minimum Data Set (MDS) dated 12/5/17, indicated R33 used side rails daily as a restraint, and required total assistance of two staff with bed mobility, and extensive assistance of 2 staff for transfers .

On 12/12/17 at 10:21 a.m. R33's bed was observed, and there were no side rails.

R30's quarterly MDS dated 11/20/17, indicated R30 used side rails daily as a restraint, and required total assistance of two staff for bed mobility and transfers.

On 12/11/17, at 7:40 p.m. R33's bed was observed with bilateral upper side rails.

R31's admission Minimum Data Set (MDS) dated 11/13/17, indicated R31 used side rails daily as a restraint, and required limited assistance of one staff for bed mobility and transfers.

On 12/11/17, at 7:05 p.m. R31's bed was observed with bilateral upper side rails.

R17's annual MDS dated 10/12/17, indicated R17 used side rails daily as a restraint, and required only encouragement or cueing with bed mobility, but required a limited assistance of one staff for transfers.

On 12/11/17, at 6:39 p.m. R17's bed was observed with bilateral upper side rails.

R191's significant change MDS dated 11/21/17, indicated R191 used side rails daily as a restraint,

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F 641	Continued From page 8 and needed only supervision or cueing for bed mobility and transfers. On 12/12/17, at 10:15 a.m. R191's bed was observed with bilateral upper side rails. R37's admission MDS dated 11/22/17, indicated R37 used side rails daily as a restraint, and required extensive assistance from one staff person for bed mobility and limited assistance for transfers. On 12/11/17, at 5:54 p.m. R37's bed was observed with bilateral upper side rails.	F 641		
F 711 SS=E	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician reviewed orders, treatments and care plans during routine	F 711	1.Residents 29, 30, 5, 15, and 1, physician orders were reviewed and signed by PCP.	2/7/18

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F 711	Continued From page 9 visits for 5 of 5 residents (R29, R30, R5, R15, and R1) reviewed for unnecessary medications Findings include: R29's Admission Record printed 12/13/17, indicated diagnoses that included Type 2 diabetes with neuropathy, kidney disorder and atrial fibrillation. R29's most recent nurse practitioner visit dated 11/9/17, lacked documentation of review of R29's orders, treatments and care plan. 12/13/17, at 10:04 a.m. the director of nursing (DON) was interviewed and stated the facility does not have the physician or provider review orders, treatments or care plans. The facility policy Physician Services - Supervision, Visits and Frequency of Visits dated 3/1/14, lacked direction on physician's review of orders, treatments and care plans. R30's Admission Record printed 12/14/17, indicated R30 had diagnoses which included cerebral palsy, and unspecified dementia with behaviors. R30's most recent nurse practitioner visit dated 10/16/17, lacked documentation of review of	F 711	2.All resident's physician orders will be reviewed/signed by PCP monthly. 3.Nurses will be reeducated on monthly PCP order requirements, policy and process. 4.Audit all physician orders received weekly for one month and then monthly for three months. 5.Audits will be reviewed at monthly QA meetings. 6.It is the responsibility of the Director of Nursing or Designee to ensure compliance.	

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F 711	Continued From page 10 orders, treatments and care plan. R5's Admission Record printed 11/1/17, indicated R5 had diagnoses that included unspecified dementia with behaviors, and Alzheimer's disease. R5's most recent physician visit dated 11/22/17, lacked documentation of review of orders, treatments and care plan. R15's Admission Record printed 12/14/17, indicated R30's diagnoses included major depressive disorder severe with psychotic symptoms. R15's most recent physician visit dated 11/15/17, lacked documentation of review of R15's orders, treatments and care plan. R1's Admission Record printed 12/14/17, indicated R1's diagnoses included unspecified dementia with behavioral disturbance. R1's most recent physician visit dated 12/11/17, lacked documentation of review of R1's orders, treatments and care plan.	F 711		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review	F 756		2/7/18

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F 756	Continued From page 11 of the resident's medical chart. §483.45(c)(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. (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. §483.45(c)(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 ensure the consultant pharmacist recommendations were addressed for 1 of 5 residents (R5) reviewed for unnecessary medications.	F 756	1.On 1/3/18 R5's PCP reviewed the pharmacy recommendation and discontinued the Ativan. 2.All residents are assessed monthly by the consulting pharmacist.	

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F 756	Continued From page 12 Findings include: R5's Admission Record printed on 11/1/17, indicated diagnoses that included unspecified dementia with behaviors, Alzheimer's Disease, anxiety, and depression. R5's quarterly Minimum Data Set (MDS) dated 9/25/17, indicated R5 was cognitively intact, had no behaviors, and had taken antianxiety and antidepressant medications each of the seven days of the assessment period. The MDS also indicated R5 had mild depression symptoms and did not reject cares. R5's Care Area Assessment (CAA) dated 4/11/17, noted the presence of depression as indicated by poor appetite, feeling tired and feeling down. The CAA further indicated R5 took antidepressant and antianxiety medication daily and family reported that R5 had always had social anxiety. R5's care plan dated 6/29/15, directed staff to monitor for target behaviors of anxiety, resisting cares, complaints of pain, and social isolation, monthly review of target behaviors for tending and effectiveness of interventions, and quarterly review of psychotropic medications for potential gradual dose reductions. R5's Physician Orders for December 2017, identified orders for sertraline HCl, (an antidepressant medication) 100 milligrams (mg) daily for depression; mirtazapine (an antidepressant medication) 15 mg once a day at bedtime for depression; clonazepam (a benzodiazepine, used to treat anxiety) 0.5 mg twice daily for anxiety; and lorazepam (an antianxiety medication) 0.5 mg daily for anxiety.	F 756	Recommendations will be forwarded to PCP for follow up of recommendation, if recommendations are returned without documentation they will be resubmitted to PCP for rational. 3.Nursing staff will be reeducated on consultant pharmacist recommendations and procedure for follow up. 4.Audit monthly for three months. 5.Audits will be reviewed at monthly QA meetings. 6.It is the responsibility of the Director of Nursing or Designee to ensure compliance.	

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A Consultant Pharmacist Communication to Physician note dated 11/9/17, indicated R5 had orders for clonazepam 0.5 mg twice a day, and lorazepam 0.5 mg daily. The consultant pharmacist CP)-A asked if R5 required two different benzodiazepine's (antianxiety medications) concurrently on a scheduled basis. CP-A asked that this duplication of therapy be reassessed. On 12/5/17, R5's physician signed the form, but did not respond to the consultant pharmacist's recommendation.

On 12/14/17, at 10:00 a.m. the director of nursing (DON) was interviewed, and verified the consultant pharmacist's recommendations had not been addressed by R5's physician. The DON confirmed MD-A had signed the consultant pharmacist recommendation form in November, but had not indicated if she accepted or rejected the recommendation, nor had she provided a rational. The DON stated she had not talked directly to the physician, nor had she discussed the lack of response with the medical director. The DON stated she would expect the resident's physician to accept or reject the consultant pharmacist recommendations, and provide a rationale within the month.

On 12/14/17, at 12:53 p.m. CP-A was interviewed, and confirmed his request to address the duplicative benzodiazepine therapy in November. CP-A stated he would expect the facility to expedite the request. The CP-A stated at times it was a challenge to get the physicians to understand the need for a response to his recommendations.

On 12/14/17, at 1:16 p.m. R5's physician (MD)-A

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F 756	Continued From page 14 was interviewed, and stated sometimes there was a miscommunication with the medication list as the nursing home and the physician's charts were on two different computer systems. MD-A confirmed she had signed the consultant pharmacist's recommendations, and had not realized that a response was needed. The facility's Pharmacy Services policy revised in 11/16, directed the DON would ensure all consultant pharmacist recommendations were followed through on a timely basis, which would not exceed 30 days.	F 756		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 883		2/7/18

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(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 883	Continued From page 15 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the influenza vaccine and education for 1 of 5 residents (R37) reviewed for immunizations. Findings include:	F 883	1.Resident 37 did receive the vaccination per policy on 11/16/17. 2.All resident charts were audited for completed influenza vaccination consent and administration.	

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 _____	12/14/2017

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F 883	Continued From page 16 R37's Admission Record printed 12/14/17, indicated R37 was admitted on 11/16/17. R37's admission Minimum Data Set (MDS) dated 11/29/17, indicated R37 was cognitively intact, and had received the influenza vaccine outside the facility. R37's Medication Review report printed 12/14/17, indicated R37's orders dated 11/16/17, directed "May have flu vaccine if no egg allergy." R37's Immunizations Record indicated R37 had received the influenza vaccine during the last flu season on 1/25/17. R37's medical record lacked evidence of the administration of the influenza vaccine and education for the current flu season. On 12/14/17, at 1:30 p.m. the director of nursing (DON) was interviewed and verified R37 had not received an influenza vaccine for the current flu season, and it should have been addressed at the time of admission. The facility policy and procedure for Immunization: Influenza revised 3/14, directed nursing to provide educational materials to the resident or resident representative regarding the risk and benefits of the influenza vaccine, and obtain and document an order for the vaccine and consent. The policy further directed nursing to offer and administer the influenza vaccine annually during the appropriate time frame as directed by the Center for Disease Control, unless contraindicated for that resident. The policy directed the resident's medication administration record should reflect whether the	F 883	3.Audit weekly for 1 month and then monthly for three months. 4.Audits will be reviewed at monthly QA meetings. 5.It is the responsibility of the Director of Nursing or Designee to ensure compliance.	

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F 883	Continued From page 17 vaccine was administered or refused. The facility policy failed to direct the review of immunizations and administration of immunizations upon admission to the facility.	F 883		

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	245138	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/18/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 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 not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR Or by email to both :	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/08/2018

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Boundary Waters Care Center is a 1-story building with no basement. The building was constructed in 1968, with an addition in 2002. Both buildings are of Type II(111) construction, therefore the building was inspected as one building. The building has an automatic sprinkler system installed throughout and also has a fire alarm system with smoke detection throughout the corridor system and in the common spaces. The facility has a capacity of 41 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101	K 901		2/7/18

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K 901	Continued From page 2 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 41 of 41 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:30 a.m. to 2:30 p.m. on 12/18/2017, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility could not provide any risk assessment documenting or proof that the risk assessment had been completed at the time of the inspection. This deficient condition was verified by a Maintenance Supervisor.	K 901	1. The NFPA Risk Assessment was completed for the community 2. The Maintenance Supervisor was educated on the K901 regulations 3. The Executive Director or designee will review the results of the NFPA Risk Assessment. These results will also be reviewed annually in the Safety and QA meeting for compliance with the regulation.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		2/7/18

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K 920	Continued From page 3 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview with the staff the facility had multiple deficient conditions affecting the facility's electrical system that were not in accordance with NFPA 70 (11), National Electrical Code. This deficient practice could negatively affect 41 of 41 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 920	1. The extension cord plugged into the corridor outlet outside the human resources office was removed 2. The three extension cords plugged into the Christmas tree in the main dining room were removed 3. All rooms in the community were assessed to ensure no extension cords were plugged into the outlets.	

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K 920	Continued From page 4 On facility tour between 10:30 a.m. to 2:30 p.m. on 12/18/2017, observations revealed the following deficient conditions: 1. There is an extension cord that is plugged into a corridor outlet that has been extended up above he ceiling tiles and is connected into a wireless router antenna located outside of the human resources office. 2. There were three extension cords plugged into the Christmas trees that are located in the main dining room. This deficient condition was verified by a Maintenance Supervisor.	K 920	4. Staff to be educated on extension cords not approved for use in the facility. 5. Executive Director or Designee will complete monthly audits for the next three months to ensure no extension cords are plugged into outlets. 6. Results will be reported and reviewed in the monthly Safety and QA meeting.	