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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SJ9X

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 **03/01/2019** (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 :
Teresa Ament, Unit Supervisor 04/26/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 04/26/2019 (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
04/18/2019
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
CMS Certification Number (CCN): 245138

April 26, 2019

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

Dear Administrator:

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 April 10, 2019 the above facility is certified 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 26, 2019

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

RE: Project Number S5138030

Dear Administrator:

On April 16, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance. Based on our review of your plan of correction, we have determined that your facility has achieved substantial compliance; therefore no remedies will 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@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: SJ9X

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00587

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(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**

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FISCAL YEAR ENDING DATE: (L35)
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Compliance Based On:
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And/Or Approved Waivers Of The Following Requirements:
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___ 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 :
Kimberly Settergren, HFE - NE II 04/01/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 04/17/2019 (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)

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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
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03-Risk of Involuntary Termination
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05-Fail to Meet Health/Safety
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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

Electronically delivered
March 18, 2019

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

RE: Project Number S5138030 and H5138021C

Dear Administrator:

On March 1, 2019, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the March 1, 2019 standard survey, the Minnesota Department of Health, completed an investigation of complaint number H5138021C that was found to be unsubstantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is April 10, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- 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 (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" 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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by June 1, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 1, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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 _____	C 03/01/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 2/25/19, through 3/1/19, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency.	E 031		4/10/19

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

Electronically Signed | 03/27/2019

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 03/01/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 031	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the emergency preparedness policies and procedures addressed the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Findings include: On 3/1/19, at 8:30 a.m. the facility's Emergency Preparedness plan dated 10/18, was reviewed. The plan lacked a procedure to obtain a waiver for and emergency declared by the Secretary, in accordance with the section 1135 of the Act. On 3/1/19, at 11:32 a.m. the administrator verified the 1135 waiver had not been addressed as part of the emergency preparedness plan.	E 031	1. Policy has been developed to address requirements for E031 regarding the procedure to obtain a waiver for an emergency declared by the Secretary, in accordance with the section 1135 of the Act. 2. Executive director, director of nursing, and key emergency staff personnel educated on E031 policy. 3. Policy will be reviewed annually 4. The Executive Director will report to QAPI on an annual basis as findings and updates of policy review for E031 are identified. 5. Compliance date 4/10/2019.	
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by:	E 035		4/10/19

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 03/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 035	Continued From page 2 Based on interview and document review, the facility failed to develop an emergency preparedness communication plan which included a method for sharing appropriate information from the plan to the residents and family members. This had the potential to affect all 39 residents currently residing in the facility. Findings include: On 3/1/19, at 11:32 a.m. the facility Emergency Preparedness plan dated 10/18, was reviewed with the facility administrator, who confirmed the plan did not address the method for sharing information the facility had determined appropriate with residents and family members/representatives.	E 035	1. Emergency Preparedness plan has been updated to include a method for sharing information the facility determines appropriate with residents and family members/representatives. This includes emergency preparedness being addressed monthly during resident council and bi-yearly through family council. 2. Executive director, director of nursing and key emergency staff personnel educated on plan update. 3. Method of communication will be reviewed annually. 4. The executive director will report to QAPI on an annual basis as findings and updates of the method of communication of E035 are identified. 5. Compliance date 4/10/2019.	
F 000	INITIAL COMMENTS On 2/25/19, through 3/1/19, a standard survey was completed at your facility. A complaint investigation was also conducted. Your facility was found not to be in compliance with requirements of 42 CFR Part 483, Subpart B and requirements for Long Term Care Facilities. The following complaint was found not to be substantiated: H5138021C 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.	F 000		

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 03/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 000	Continued From page 3 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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(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); (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	F 580		4/10/19

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 03/01/2019

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

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F 580	Continued From page 4 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). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure notification of the physician and the resident representative regarding a resident's expression of suicidal thoughts for 1 of 4 residents (R18) reviewed for behavioral health and mood concerns. Findings include: R18's Face Sheet printed 3/1/19, indicated R18 had diagnoses that included major depressive disorder. R18's quarterly Minimum Data Set (MDS) dated 10/8/18, indicated R18 had intact cognition. On 2/26/19, at 2:29 p.m. R18 was interviewed and stated he had been suicidal, up until maybe a week or two ago. R18 stated the facility never	F 580	1. Resident 18 was evaluated by his primary care provider. He was started on vilazodone 10 mg by Mouth every pm for major depression. Orders were received to re-establish therapy services. He was evaluated on 3/18/19 for therapy services. R 18's Behavior Monitoring Record was updated to include suicidal thoughts and threats of harm to self. R18's care plan was updated with person centered behavioral health interventions. 2. Immediate notification to the ED/DON will occur if a resident makes statements of intent to harm self. Resident will be sent to the emergency department if the primary care provider is not available to see the resident immediately. The resident's environment will be evaluated	

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F 580	Continued From page 5 gave offered him to see a physician or therapist about his thoughts of suicide when he reported to them his suicidal thoughts. R18 stated he had seen a therapist for depression, years ago. R18 indicated he wanted to escape (die), but now he has accepted his illness. R18 stated he would still like to see a therapist, and believed it would be helpful for his depression. R18's progress note dated 10/1/18, indicated R18 made statements to staff that he wanted to die. Staff reported to the director of nursing (DON) and administrator. The facility initiated 15 minute checks, and faxed R18's primary MD for treatment of pain and anxiety. The fax identified R18 had behaviors which included insomnia, negative comments, and verbalizing he wishes he would die. The fax lacked identified of R18's thoughts of self-harm or suicidal ideation. On 10/18/19, R18 was seen by his MD for medication review. The MD note lacked any indication the MD was aware of R18's suicidal thoughts. On 2/26/19, at 2:40 p.m. family member (FM)-A stated the facility failed to notify him that R18 had thoughts of self-harm or suicidal ideation. FM-A indicated this was concerning giving R18's history of mental illness and depression. FM-A also indicated there was a family history of suicide, R18's brother had committed suicide, and he would have wanted his father seen by a physician. On 2/26/19, at 4:38 p.m. the DON was interviewed and verified the fax sent to R18's physician included pain and anxiety. The DON verified the fax did not include R18's thoughts of	F 580	and any items that may be used to harm self will be removed from the area. 1:1 supervision will be provided until the resident is transferred to the emergency department or seen by the primary care provider. Residents family will be notified immediately of any statement of intent to harm self. 3. Residents who have symptoms of worsening depression will be referred to their primary care provider to be evaluated for appropriate treatment and services. 4. All current residents have been assessed for signs/symptoms of worsening depression. 5. Nursing staff have been educated on the proper way to respond to threats of harm to self and signs/symptoms of worsening depression. 6. IDT will review at least quarterly: - specific resident behaviors, - appropriateness and effectiveness of interventions for depression or thoughts of harm to self, - current medications – including pharmacist recommendations related to psychotropic medications, - Psych service recommendations, - AIMS findings. 7. Audits will be conducted weekly for four weeks, then once a month for two months. 8. DON/Designee will report results and	

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F 580	Continued From page 6 self-harm or suicidal ideation. On 2/27/19, at 2:18 p.m. the administrator stated he was not aware R18's family was not notified of his comments of suicide, and stated it was his expectation that the family would be called. The administrator further stated he was not aware R18's physician was not informed of his comments of suicide, and stated he should have been informed immediately. The facility policy Change in a Resident's Condition or Status dated 3/1/19, directed staff to notify the resident's representative when there was a significant change in the resident's physical, mental or psychosocial status, and this notification was to be made within 24 hours. The policy also directed the resident's attending physician or physician on call or nurse practitioner and responsible party will be notified with changes in resident's condition or health status.	F 580	trends of all audits to QAPI committee for review monthly for 3 months and follow up as needed. 9. Compliance date 4/10/2019.	
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 609		4/10/19

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F 609	Continued From page 7 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a policy to report suspected abuse to the state agency (SA) immediately within 2 hours for 4 of 5 residents (R190, R36, R34, and R21) reviewed for abuse. Findings include: R190's Admission Record printed 3/1/19, indicated R190's diagnoses included generalized anxiety disorder, and obsessive compulsive disorder. R190's care plan initiated 12/27/13, indicated R190's potential vulnerabilities included hearing impairment and cognitive deficits related to dementia, and R190's goal was not to be the victim of abuse. R190's care plan further indicated R190 had limited physical mobility and required extensive to total assistance with activities of daily living (ADLs) and was receiving hospice services.	F 609	1. The facility policy on Freedom From Abuse, Neglect and Exploitation has been reviewed. 2. Other self-reports reviewed for timeliness. 3. Staff have been educated on immediate notification to the Executive Director of any suspected or actual violation of the facility policy on Freedom From Abuse, Neglect and Exploitation. The facility Executive Director of Designee will report any reports of suspected abuse, neglect or exploitation to the state agency within 2 hours of notification. 4. Audits will be conducted weekly for four weeks, then once a month for two months. 5. E.D./DON will report results and trends	

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F 609	Continued From page 8 A Nursing Home Incident Reporting-Investigation Report Summary (NHIR-IRS) dated 10/31/18, indicated R190 was discovered to have a fluid filled blister with two open areas with serosanguinous fluid on the left lateral foot, on 10/24/19, at 4:30 a.m. related to a burn from the heat register next to R190's bed. R190's vulnerable adult report to the SA, indicated this incident was reported to the SA on 10/24/18, at 12:01 p.m. R36's Admission Record printed 3/1/19, indicated R36's diagnoses included anxiety disorder and disorientation. R36's care plan initiated 2/12/18, indicated R36 had symptoms of depression, a cognitive impairment, had physically aggressive behaviors, and required extensive assistance with ADLs. R36's care plan further indicated R190's vulnerabilities included dementia, hearing deficit, and behaviors which could be disruptive to others. R36's care plan goal was R36 would not be the victim of abuse. A NHIR-IRS dated 10/17/18, indicated R36 had purposefully been given a call light that was not plugged in and non-functional to hold on to and was given a nail polish bottle to hold on to in place of a call light, because R36 frequently put on the call light. R36's report indicated staff did not timely report to the administrator and SA. R34's Admission Record printed 3/1/19, indicated R34's diagnoses included failure to thrive and repeated falls. R34's care plan initiated 8/9/18, indicated R34's vulnerabilities included weakness, failure to	F 609	of all audits to QAPI Committee for review monthly for 3 months and follow up as needed. 6. Compliance date 4/10/2019.	

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F 609	Continued From page 9	F 609		

thrive, dementia, refusal of cares and behaviors. R34's care plan further indicated R34 required extensive to total assistance with ADLs and mobility, had physically aggressive behaviors,

R34's NHIR-IRS dated 11/26/18, indicated on 11/20/18, at 8:00 p.m. R34 was purposefully hit in the face by a nursing assistant with a washcloth from behind. The incident was reported to the SA on 11/21/19, at 12:48 p.m. R34's NHIR-IRS indicated the vulnerable adult reporting policy was not followed.

R21's Admission Record printed 3/1/19, indicated R21's diagnoses included major depressive disorder and anxiety disorder.

R21's care plan initiated 1/16/19, indicated R21's vulnerabilities included weakness and R21's goal was that R21 would not be the victim of abuse. R21's care plan further indicated R21 displayed verbal behaviors, had a terminal prognosis, required set up to minimal assistance with ADLs and extensive assistance with mobility,

R21's NHIR=IRS dated 2/14/19, indicated R21 reported a verbal altercations with staff on the evening of 2/10/19. R21's NHIR=IRS indicated the report to the SA was submitted on 2/11/19, at 12:28 p.m. and the facility vulnerable adult policy was not followed.

On 3/1/19, at 1:29 p.m. the administrator verified the vulnerable adult policy for abuse was the current policy and procedure, and it directed staff to report suspected abuse to the state agency as soon as possible, but no longer than 24 hours. The administrator stated new staff were educated on the policy, and sign a statement that they

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F 609	Continued From page 10 received and reviewed the abuse policy, and were to report abuse immediately within 2 hours if serious bodily injury, and otherwise within 24 hours. The administrator verified the following incidents were potential abuse and were willful acts except for R190, though was a serious bodily injury. -R190: occurred on 10/24/18, at 4:30 a.m. and was reported to the SA on 10/24/19, at 12:01 p.m. -R36: occurred on 10/10/18, at 2:00 a.m. and was reported to the SA on 10/10/18, at 10:17 a.m. -R34: occurred on 11/20/18, at 8:00 p.m. and was reported to the SA on 11/21/18, at 12;48 p.m. -R21: occurred on 2/10/19, at 3:15 p.m. and was reported to the SA on 2/11/19, at 12:28 p.m. The facility policy and procedure Freedom from Abuse, Neglect, and Exploitation revised 11/16, directed staff to immediately report and alleged violation of abuse, with immediately defined as, as soon as possible, but not to exceed greater than 24 hours after discover of the incident. The policy and procedure lacked guidance to report all suspected abuse allegations to the SA in less than 2 hours. An undated facility statement titled Freedom from Abuse, Neglect, and Exploitation Policy Acknowledgement, to be signed by new staff indicated they had received and reviewed the abuse policy, and were to immediately report any suspected maltreatment to the administrator in less than 2 hours if the incident caused serious bodily injury, or no later than 24 hours if the events did not cause serious bodily injury.	F 609		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		4/10/19

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F 623	Continued From page 11 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30	F 623		

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F 623	Continued From page 12 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to	F 623		

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F 623	Continued From page 13 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written notification of transfer to the hospital was provided for 3 of 3 residents (R7, R4, R12) reviewed for hospitalizations. This had the potential to affect all residents residing in the facility. Findings include: R7's Admission Record printed 3/1/19, indicated R7's diagnoses included diabetes, leukemia, urethral stricture, and retention of urine. R7's progress notes dated 12/6/18, indicated R7 had gone to a urology appointment and was sent to the emergency room from the appointment, and returned to the facility on 12/8/18, with a diagnosis of a urinary tract infection. R7's progress notes lacked evidence that written notification of reason for transfer was provided to R7 or R7's representative.	F 623	1. The facility policy on Admission, Transfer and Discharge has been reviewed and updated to include directions to provide written notification of the reason for transfer to the resident or their representative. 2. Other residents or representatives have been provided the appropriate notification of the reason for transfer. 3. Nurses have been educated on the Admission, Transfer and Discharge Policy. Nurses are to provide the resident or their representative the written notification of the reason for transfer at time of transfer or by phone to resident representative if not present at time of transfer. 4. Audits will be conducted weekly for four weeks, then once a month for two	

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F 623	Continued From page 14 R7's progress notes dated 1/30/19, at 10:32 p.m. indicated R7 was sent to the emergency room at approximately 7:00 p.m. for abdominal pain and pain near the catheter site. R7's progress notes lacked evidence that written notification of reason for transfer was provided to R7 or R7's representative. R7's progress note further stated R7 returned from the emergency room the same evening. On 2/25/19, at 6:34 p.m. R7 stated he had gone to the hospital about 4 times in the past 3 months, and no written notification of reason for hospital transfers had been provided. On 3/1/19, at 10:45 a.m. the director of nursing (DON) stated a the facility did not provide a written notification of reason for hospital transfers. The facility policy and procedure for Admission, Transfer and Discharge revised 9/17, directed upon transfer of a resident to an alternative provider, documentation would include the reason for transfer, but lacked direction to provide a written notification of the reason for transfer to the resident or resident representative. R4's Face Sheet printed 3/1/19, included diagnosis of chronic obstructive pulmonary disease, and emphysema. R4's progress note dated 9/30/18, indicated R4 was sent to the emergency room on 9/30/18, with abdominal pain, nausea and dizziness. R9 returned to the facility on 9/30/18. R4's progress note dated 10/5/18, indicated R4	F 623	months. 5. E.D./Designee will report results and trends of all audits to QAPI committee for review monthly for 3 months and follow up as needed. 6. Compliance date 4/10/2019.	

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F 623	Continued From page 15 was sent to the emergency room again on 9/30/18, with concern of possible esophageal bleed, abdominal pain, nausea and dizziness. R4 was admitted to the hospital admitting diagnosis of esophageal bleed. R9 returned to the facility on 10/5/18. R4's medical record lacked notification to the resident and/or the resident's representative(s) of the transfer or discharge, and the reasons for the move in writing.	F 623		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide routine grooming to remove facial hair for 1 of 4 residents (R32) reviewed for activities of daily living (ADLs) and who was dependent on staff for ADL assistance. Findings include: R32's Admission Record printed 2/26/19, indicated R32's diagnoses included chronic bronchitis, and mild cognitive impairment. R32's quarterly Minimum Data Set (MDS) dated 12/3/18, indicated R32 had moderate cognitive impairment. The MDS also indicated R32 required extensive assistance with dressing, and was independent performing personal hygiene with setup assistance.	F 677	1. R32 had chin hair removed. 2. Other residents have been assessed for routine grooming of facial hair and care plans/care guides have been updated to include removal of facial hair, the resident's preferences and assistance needed. 3. Nursing staff have been educated on the facility policy for Shaving and the updated care plans/ care guides. 4. Audits will be conducted weekly for four weeks, then once a month for two months. 5. DON/Designee will report results and trends of all audits to QAPI committee for	4/10/19

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F 677	Continued From page 16 R32's Care Area Assessment (CAA) undated, indicated R32 had impaired cognition and suffered from mild short-term memory loss. The CAA further indicated staff was to re-orient and cue R32, as needed. During an observation on 2/26/19, at 9:36 a.m. R32 was noted to have stubble on his face. R32 indicated he preferred to be clean shaven, and staff had helped him with this "sometimes." During an observation on 2/27/19, at 11:20 a.m. R32 was sitting in his wheelchair outside of physical therapy. R32 was not shaved and his facial hair appeared to be longer than the previous day. During an observation on 2/28/19, at 8:14 a.m. R32 was observed sleeping, in the dining area, sitting in his wheelchair. R32 was not shaved and his facial hair appeared to be longer than the previous day. During an observation on 3/1/19, at 9:18 a.m. R32 was observed in the dining area sitting in his wheelchair. R32's facial hair appeared longer than previous days. On 2/28/19, at 3:25 p.m. an interview was conducted with nursing assistant (NA)-D. NA-D stated R32 was able to shave independently. NA-D further stated R32 seemed to be becoming more forgetful. On 2/28/19, at 3:57 p.m. an interview was conducted with NA-A. NA-A stated a month ago R32 required setup assistance, however, R32 now required additional assistance with personal	F 677	review monthly for 3 months and follow up as needed. 6. Compliance date 4/10/2019.	

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hygiene. NA-A further stated R32's ability to shave was "touch and go."

On 3/1/19, at 9:20 a.m. a follow-up interview was conducted with R32. R32 again stated he preferred to be clean shaven.

On 3/1/19, at 9:38 a.m. an interview was conducted with NA-B. NA-B stated R32 was starting to require more care. NA-B further stated she was unsure what was happening to R32 cognitively, but he had required additional prompting. NA-B also stated R32 was not making decisions like putting on his shirt, and was having difficulty making "connections." NA-B confirmed R32 was not prompted to shave during the shift.

On 3/1/19, at 9:50 a.m. an interview was conducted with registered nurse (RN)-A. RN-A stated R32 required limited assistance with ADLs, however, required prompting to complete tasks. RN-A further stated R32 was cognitively declining, and had visited his physician the prior week and had medication adjustments.

On 3/1/19, at 10:12 a.m. an interview was conducted with the director of nursing (DON). The DON stated R32 had an overall decline which was noticeable the last month. The DON further stated R32 required extensive assistance brushing his teeth and shaving. The DON stated the expectation was the resident should be shaved if he wanted it completed.

The facility policy Shaving - Safety Razor dated 4/1/18, directed, "Resident will be provided care and services daily which includes shaving as per resident needs and/or care plan."

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F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure Provider Orders for Life Sustaining Treatment (POLST) was completed in accordance with resident preferences for 1 of 3 residents (R22) reviewed for advanced directives. Findings include: R22's Admission Record printed 2/26/19, indicated R22's diagnoses included mild intellectual disabilities, anxiety disorder, chronic kidney disease, major depressive disorder, and unspecified dementia. R22's quarterly Minimum Data Set (MDS) dated 1/21/19, indicated R22 was cognitively intact. R22's Medication Review Report dated 2/26/19, indicated R22 was a full code resuscitation status (wanted CPR). R22's care plan dated 9/14/17, indicated R22 was a full code resuscitation status. The care plan further revealed R22 had a health care decision maker, and the healthcare decision maker "wishes" for R22 "would be honored ongoing." R22's Honoring Choices Minnesota Health Care Directive was completed by R22 on 5/26/17, and	F 678	1. Resident 22 POLST was reviewed and updated immediately. Resident #22 POLST was reviewed and orders obtained to reflect code status. 2. Other residents POLST forms were reviewed on 2/26/19. Any POLST forms signed by the resident representative for a resident who had a BIMS score of 7 or less were reviewed and updated with the resident's wishes and signed by the resident to ensure residents resuscitation preferences are honored. Resident representatives were notified of any changes. 3. Nurses have been educated on the Advance Directive and Rights Regarding Treatment policy. Nurses have been educated on the location of the POLST information. 4. Audits will be conducted weekly for four weeks, then once a month for two months. 5. DON/Designee will report results and trends of all audits to QAPI Committee for review monthly for 3 months and follow up	4/10/19

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F 678	Continued From page 19 notarized on 5/26/17. The document identified a primary Health Care Agent and directed, "If I cannot communicate my wishes and health care decisions due to illness or injury, or if my health care team determines that I cannot make my own health care decisions, I choose the following person to communicate my wishes and make my health care decisions. My Health Care Agent must: " Follow my health care instructions in this document. " Follow any other health care instruction I have given to him or her. " Make decisions in my best interest." The document further revealed R22's initialed boxes on the health care directive which directed "I want CPR [cardiopulmonary resuscitation] if by heart or breathing stops" and "I want CPR attempted if my heart or breathing stops based on my current state of health. However, in the future if my health has changed; for example; " I have an incurable illness or injury and am dying " I have no reasonable chance of survival if my heart or breathing stops " I have little change of long-term survival if my heart of breathing stops and CPR would cause significant suffering then my agent or I (if I am able) should discuss CPR with my health care team." A progress noted dated 7/19/18, at 7:42 a.m. indicated a care conference was held on 7/18/18. The progress note further indicated R22 did not want to attend the care conference per R22's	F 678	as needed. 6. Compliance date 4/10/2019.	

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F 678	Continued From page 20	F 678		

sister, due to an "outburst" that occurred during lunch. The progress note revealed R22's code status was modified to do-not-resuscitate (DNR) / do-not-intubate (DNI) during the care conference.

R22's Provider Orders for Life Sustaining Treatment (POLST) indicated R22 resuscitation status was DNR. The POLST document was signed by R22's Health Care Agent on 7/18/18. The basis for orders section revealed boxes were checked indicating, "HEALTH CARE DIRECTIVE/LIVING WILL," and "BEST INTEREST."

On 2/25/19, at 7:05 p.m. an interview was conducted with registered nurse (RN)-B. RN-B stated the facility used a blue dot system to determine a resident's code status. RN-B further stated if a blue dot was placed on a resident's nameplate outside their room, it indicated CPR was to be performed.

On 2/25/19, at 7:06 p.m., an observation was conducted of R22's nameplate, outside of the room. The nameplate contained a blue dot, which indicated CPR status.

On 2/25/19, at 7:13 p.m., an interview was conducted with nursing assistant (NA)-A. NA-A stated if a resident was found without a pulse they would notify the nurse. NA-A further indicated if a blue dot was placed on a resident's room nameplate, it indicated CPR was to be performed.

On 2/25/19, at 7:46 p.m., an interview was conducted with R22. R22 stated if her heart had stopped beating she would like CPR to be performed. R22 further stated she had always wanted CPR performed, and hoped to be around

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F 678	Continued From page 21	F 678		

for a long time.

On 2/25/19, 7:54 p.m. an interview was conducted with RN-B. RN-B stated if a resident was found pulseless she would determine a residents code status by checking for a blue dot on the residents nameplate located outside of their room. RN-B further stated she could also check a resident's paper medical record for a blue dot which also indicated to perform CPR.

On 2/25/19, at 8:32 p.m. an interview was conducted with the director of nursing (DON). The DON confirmed the process for determining a residents code status was to check for a blue dot on the nameplate outside of a residents room. The DON also confirmed the POLST for R22 directed DNR. The DON stated R22 had a Health Care Agent who had signed the POLST for R22. The DON further stated she was unsure if any documentation existed declaring the Health Care Agent was authorized to make decisions on R22's behalf. During this time, R22's paper medical record was observed. It lacked a blue dot.

On 2/26/19, at 8:40 a.m. the blue dot located on R22's nameplate outside her room was observed to be removed.

On 2/26/19, at 10:22 a.m. an interview was conducted with licensed practical nurse (LPN)-A. LPN-A stated if a resident was found pulseless, she would check the resident nameplate for a blue dot. LPN-a further indicated she would check a resident's paper medical record if a resident experienced a cardiac arrest in the commons area as it was in closer proximity.

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F 678	Continued From page 22 On 2/26/19, at 10:27 a.m. an interview was conducted with the DON. The DON verbalized a care conference was held with R22's Health Care Agent, and it was decided to R22's change R22's code status to DNR. The DON further verbalized the appointed Health Care Agent was R22's Health Care Power of Attorney. The DON stated she was unsure if R22 was deemed incapable of making her own health care decisions. The DON further stated she was unsure if R22's Health Care Agent had a discussion with R22 regarding the change in code status. The DON confirmed she had removed the blue dot from R22's nameplate. On 2/26/19, at 10:36 a.m. an interview was conducted with social worker (SW)-A. SW-A stated R 22 was cognitively intact, and knew what she wanted to do. SW-A further stated she believed residents should be aware of decisions made in a care conferences when they were not present. On 2/26/19, at 2:38 p.m. an interview was conducted with the administrator. The administrator verbalized residents should be involved in discussions regarding their resuscitation status, if able. The administrator confirmed if staff would had looked at the POLST, R22's wishes would not have been followed. The administrator also confirmed the facility should have talked to R22 about her resuscitation wishes. The administrator also stated the facility should assess a resident's ability to make health care decisions if it was felt a resident was not competent to do so. The administrator was not aware the blue dot from R22's room was removed.	F 678		

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F 678	Continued From page 23	F 678		

On 2/26/19, at 3:04 p.m. a follow-up interview was conducted with the DON. The DON stated the blue dot was removed from R22's room nameplate because R22's POLST directed DNR status. The DON verbalized R22's resuscitation status was changed to DNR because her Health Care Agent made the decision. The DON stated she was unaware if R22 was deemed incapable of making health care decisions, and confirmed the facility lacked documentation which indicated R22 was incapable of making health care decisions.

On 2/26/19, at 4:35 p.m. a follow-up interview was conducted with R22. R22 described CPR as, "When they press on your chest to get your heart beating," and they breathe for you. R22 again confirmed she wanted CPR performed.

On 2/26/19, at 4:50 p.m. a blue dot was observed on the nameplate outside R22's room. Additionally, an updated POLST directing CPR was signed by R22.

On 2/28/19, at 10:29 a.m. a follow-up interview was conducted with the Administrator and SW-A. SW-A indicated R22 usually refused to attend care conferences and R22's Health Care Agent attended the meetings. The Administrator indicated R22 was able to say what she wants, but also changed her mind a lot. SW-A indicated R22's cognition was fine. The Administrator verbalized if a residents code status was changed, without their knowledge, the facility should check with the resident to ensure they were okay with it. SW-A also confirmed a resident should be involved in decisions about their care when they chose not to attend care conferences.

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F 678	Continued From page 24 R22's medical record lacked indication she was incapable of making heath care decisions. The facility policy Cardiopulmonary Resuscitation (CPR) revised 11/16, directed each resident's CPR preference will be expressed in Advance Directive documents such as a living will, a Power of Attorney for Health Care Document, or a CPR preference form. The policy further directed, "The right to formulate an advance directive applies to each and every individual." The facility policy Advance Directives and Rights Regarding Treatment revised 11/16, directed, "The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive." The policy further directed, "The community promotes these rights by: " Informing and educating the resident about these rights and the community's policies regarding exercising these rights; " Helping the resident to exercise these rights; and " Incorporating the resident's choices regarding these rights into treatment, care and services" The policy also directed, "The community will periodically assess the resident for decision making capacity and invoke the health care agent or legal representative if the resident is determined not to have decision-making capacity (according to state law or process)."	F 678		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		4/10/19

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F 684	Continued From page 25 § 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 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure compression (TED) socks were provided according to the care plan for 1 of 2 residents (R18) reviewed for quality of care. Findings include: R18's Face Sheet printed 3/1/19, indicated R18 had diagnoses that included hypertension, diabetes mellitus, and atherosclerotic heart disease. R18's quarterly Minimum Data Set (MDS) dated 10/8/18, indicated R18 had intact cognition. R18's Physician Orders dated 2/26/19, indicated R18 was to have TED socks on in the morning and off in the evening daily. On 2/27/19, at 7:59 a.m. R18 was observed in the main dining room, and was not wearing TED socks. On 2/28/19, at 9:04 a.m. R18 was observed sitting in the wheelchair in his room. R18 was not wearing TED socks, and his lower legs were edematous.	F 684	1. R18 was measured for TED socks and was given a new TED socks. R18 has since been refusing to wear TED socks daily. Risk vs benefits have been reviewed with R18. 2. Other residents who have orders for TED socks have been assessed to ensure they are wearing TED socks as ordered. Audits of accurate documentation of the application of TED socks have been completed for all residents who wear TED socks. 2. Nursing assistants have been educated in reporting to the nurse when a resident is missing TED socks and resident refusals to follow the plan of care. Nursing assistants had been educated on the policy for Elastic Anti-embolic Hose Application. 3. Nurses have been educated on the proper documentation of care, the policy on Elastic Anti-embolic Hose Application and Risk vs benefits. 4. Audits will be conducted weekly for	

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F 684	Continued From page 26 On 2/28/19, R18's treatment record was reviewed, and indicated staff had been signing that R18 was wearing his TED socks every day in February. On 2/28/19, at 9:17 a.m. nursing assistant (NA)-A stated R18 was to have TED socks on, and they were part of his care plan. NA-A verified TED socks are on the daily care sheets for the nursing assistants. NA-A indicated R18 has not had the TED socks on for a long time. On 2/28/19, at 9:22 a.m. registered nurse (RN)-A verified R18 was to have TED socks on daily in the morning and off in the evening. RN-A stated R18 was at risk for stroke, and required the physician ordered TED socks. RN-A verified the NA staff have been signing as providing the TED socks for R18 the entire month of February. On 2/28/19, at 2:52 p.m. the director of nursing (DON) stated the expectation was that staff only sign off on cares they had provided. The DON indicated TED socks were important for R18 due to his history of stroke, cardiovascular disease, and edema. The DON stated it was her expectation that all staff are following the care plan and physician orders. A policy for compression stockings and or TED socks was requested, but not received.	F 684	four weeks, then once a month for two months. 5. DON/Designee will report results and trends of all audits to QAPI Committee for review monthly for 3 months and follow up as needed. 6. Compliance date 4/10/2019.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		4/10/19

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F 689	Continued From page 27 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure falls were reassessed and interventions were reevaluated to prevent falls for 2 of 6 residents (R1, R32) reviewed for accidents. In addition, the facility failed to transfer a resident as directed by physical therapy (PT) assessment and the care plan for 1 of 1 residents (R17) reviewed for urinary incontinence. Findings include: R1's Admission Record printed 3/1/19, indicated R1's diagnoses included dementia, and Alzheimer's disease. R1's significant change Minimum Data Set dated 11/25/18, indicated R1 had severe cognitive impairment. The MDS further indicated R1 required extensive assistance with transfers and toilet use. Additionally, R1 had a functional limitation to one side of the lower extremity, and had two or more falls with no injury. R1's vision Care Area Assessment (CAA) undated, indicated R1 was blind. Additionally, R1's CAA for urinary incontinence undated, indicated R1 was frequently incontinent of bladder, and identified R1 did not voice the need to void unless asked. R1's falls CAA undated, indicated R1 was at risk	F 689	1. Residents # 17 has been observed to be transferred according to the plan of care. NA-E was re-educated on the following the resident's care plan for transfers. 2. All incidents/accident are reviewed by the IDT to determine root cause. Appropriate interventions are implemented to prevent any further incidents/accident and care plans are updated to reflect any changes. 3. Other residents reviewed to ensure they are transferred according to their plan of care. 4. Nursing staff have been educated on the incident/accident policy as well as completing the post fall assessment completely and accurately; and following the resident's care plan for transfers. 5. Audits will be conducted weekly for four weeks, then once a month for two months. 6. DON/Designee will report results and trends of all audits to QAPI Committee for review monthly for 3 months and follow up as needed.	

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F 689	Continued From page 28 for falls due to dementia, blindness, and psychotropic drug use. The CAA further indicated R1 did not use her call light, and hollered out when she needed help. R1's care plan printed 3/1/19, indicated R1 was at risk for falls related to confusion, blindness, incontinence, psychoactive drug use, unawareness of safety needs, and wandering. R1's goal was to remain free of falls. Interventions included: stay in public areas when in Broda Chair (specialized wheelchair) and not accompanied by family; room change to be closer to nurses' station; call light within reach; nursing staff to ambulate R1 with gait belt when she was restless and would allow; nursing staff to monitor closely while in Broda Chair in lounge area; toilet every two hours and give water to drink after toileting; nursing to monitor more closely for signs and symptoms of anxiety and/or pain; paddle style call light for easier use; safety and activity checks every 15 minutes; toilet R1 when roommate asks for toileting assistance; anticipate and meet needs; ensure appropriate footwear (non-skid); follow facility fall protocol; ensure safe environment; and encourage and remind R1 to use call light; and, provide prompt response for requested assistance. R1's Incident/Accident Forms and Nurses Notes indicated the following falls: An Incident Report dated 1/26/17, at 5:31 a.m. indicated R1 was found on the floor and unable to express why she fell. Actions to prevent recurrence included every two hour toileting. No injuries were noted. An Incident Report dated 1/29/18, at 10:30 a.m.	F 689	7. Compliance date is 4/10/2019.	

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indicated a family member attempted to transfer R1 from her recliner to a wheelchair, and lowered R1 to the ground when she lost her balance. Family was instructed not to transfer R1.

A nurses note dated 2/6/18, at 9:45 a.m. indicated staff found R1 sitting on the floor at the foot of her bed, and in front of the bathroom doorway. R1's incontinent brief was wet. An Incident Report dated 2/6/18, at 4:30 a.m. indicated R1 was found on the floor in her bathroom, and not responding appropriately. Actions to prevent recurrence included every two hour toileting. No injury was noted.

A nurses note dated 3/2/18, at 9:38 p.m. indicated R1 was found sitting on the floor between her wheelchair and bed at 7:50 p.m. A nursing assistant (NA) indicated they were going to get assistance putting R1 to bed, and family had left the room. Upon the NA's return to the room, in less than five minutes, R1 was sitting on the floor. R1's roommate indicated R1 slid from her wheelchair. An Incident Report dated 3/2/18, at 7:50 p.m. indicated actions to prevent recurrence included not leaving R1 unaccompanied in her wheelchair while in her room. No injury was noted.

A nurses note dated 5/3/18, at 7:16 a.m. indicated, at 4:15 a.m. staff heard a call for help. R1 was found seated in front of the sink, in her room, with water running and urine in the toilet. An Incident Report dated 5/3/18, at 4:15 a.m. indicated actions to prevent recurrence included encouraging R1 to use the bathroom each time her roommate was toileted during the night. No injury was noted.

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A nurses note dated 6/3/18, at 1:30 a.m. indicated R1 was climbing out of bed. R1 verbalized she had to "get to the house." R1 refused to go to the bathroom and did not want to go back to bed. R1 was slapping at the nurse and attempted to ambulate independently. R1 was also noted to yell, "Help me," and attempted to wander into other resident's rooms. Staff closed doors and kept R1 from falling until she got tired. R1, who was still yelling, then sat in a wheelchair and was wheeled to the commons area. R1 was trying to sit in an armchair, after about 30 minutes, and yelling, "Help me" and "Help me murder" repeatedly. R1 was assisted to the armchair and provided a pillow and blanket. R1 continued to yell out and was administered lorazepam (antianxiety medication) at 12:20 a.m. and was noted to "doze off." R1 was assisted to bed at 12:45 a.m. and was noted to be sleeping at 1:00 a.m.

A nurses note dated 6/3/18, at 6:52 a.m. indicated that at 3:15 a.m. staff heard a faint "help me" from down the hall. R1 was found lying on her right side, hugging blankets, in front of her bed. R1 was bleeding from a hematoma which was on the left side of her head. R1 also complained of left upper leg pain. R1 was transferred to the emergency department where she was diagnosed with a fractured left hip. An incident report dated 6/3/18, indicated at 3:15 a.m. R1 was found on the floor, confused, had a laceration to the left side of her head, and complained of left upper leg pain. Lorazepam was given to R1 at 12:20 a.m. Actions to prevent recurrence included reeducating staff on agitation and giving medication.

An incident report dated 8/5/18, at 1:50 p.m.

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indicated R1 was found on the floor in the lobby. R1 had attempted to self-transfer from a wheelchair to a couch. No injury was noted. R1's blood pressure was 99/56. Intervention included toileting, and placing on couch after meals.

A nurses note dated 10/14/18, at 3:54 a.m. indicated R1 was found on the floor at 1:35 a.m. when she was heard asking for water. R1 was sitting on a floor mat and leaning against her bed with blankets wrapped around her. R1 had a soiled incontinent brief on top of the bed. Nursing assistants were instructed to toilet R1 when her roommate called for toileting. An Incident Report dated 10/14/18, at 1:35 a.m. indicated R1 was found on the floor, next to her bed, with stool noted on R1 and her blankets. Education was provided to staff to toilet R1 when her roommate was toileted. Actions to prevent recurrence included check and change every two hours, and to offer water during each resident check. R1's Post Fall Investigation Assessment revealed R1 was last toileted at 10:45 p.m. No injury was noted.

An Incident Report dated 11/9/18, at 11:20 a.m. indicated R1 was found sitting between her wheelchair and couch, on the floor, in the lobby area. Blood pressure was 90/56. Interventions to prevent recurrence included nursing staff to continue to monitor closely when in wheelchair. R1 was noted to be incontinent of urine. R1 was toileted 40 minutes prior to the fall. No injury was noted.

A nurses note dated 11/30/18, at 1:43 p.m. indicated R1 had a fall at 9:45 a.m. R1 was found sitting on the floor, next to her bed, by an activities aide. An Incident Report dated

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11/30/18, at 9:45 a.m. indicated actions taken to prevent recurrence included check and change R1 every two hours. No injury was noted from this fall. The Post Fall Investigation Assessment indicated R1 was "checked before breakfast" (for incontinence). No injury was noted.

An Incident Report dated 12/1/18, at 2:45 p.m., indicated R1 was found sitting on the floor in the room after staff received a report from a visitor. R1 verbalized, "I'm looking for someone." Actions taken to prevent recurrence included leaving gripper socks on at all times. The report also noted R1 appeared to get agitated after laying down after a meal. No injuries were noted from this fall.

A nurses note dated 12/6/18, at 12:52 p.m. indicated R1 was sitting on the floor leaning up against her bed, at 7:15 a.m. An Incident Report dated 12/6/18, at 7:15 a.m. indicated R1 was found on the floor, beside her bed, by staff who heard her yelling. R1 was noted to be restless at the time of the fall. Interventions to prevent recurrence included monitoring for signs and symptoms of anxiety. No injuries were noted from this fall.

An Incident Report dated 12/13/18, at 2:00 p.m. indicated R1 was found sitting on the floor in her room. R1's call light was activated and she expressed, "I want to take a nap." The Incident Report lacked indication of when R1 was last toileted or repositioned.

An Incident Report dated 12/15/18, at 10:15 p.m. indicated R1 was found on the floor, next to her bed, incontinent of urine. Actions taken to prevent recurrence included toileting every two

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hours. The Post Fall Investigation Assessment indicated R1 was checked and changed at 10:00 p.m. No injury was noted.

An Incident Report dated 12/19/18, at 7:25 p.m. indicated R1 was found on a floor mat by staff, when she was yelling, "Help me." R1 stated, "I needed to use the pot." Interventions to prevent recurrence included placing a concave mattress on R1's bed. The Post Fall Investigation Assessment indicated R1's call light was not within reach, and she was last toileted at 6:00 p.m.

An Incident Report dated 12/20/18, at 3:15 p.m. indicated R1 was found on the floor in her room and yelling for help. R1 verbalized, "I need to get to the other bed." Staff education was provided regarding frequent rounding. Actions to prevent recurrence included moving R1 to a room closer to the nurses' station.

An Incident Report dated 12/22/18, at 10:00 p.m. indicated R1 was found "wrapped around toilet and a basin on the floor and also urine on the floor in front of toilet." R1 verbalized, "I was looking for the baby." Intervention to prevent recurrence included changing R1's call light to a paddle style. R1 was last toileted at approximately 8:00 p.m. No injury was noted from this fall.

A nurses note dated 12/23/18, at 2:32 p.m. indicted R1 was found sitting on the floor. The facility lacked an Incident Report for this fall.

An Incident Report dated 12/28/18, at 1:55 p.m. indicated R1 was found on the floor in her room. R1 expressed to staff she "was going to see the

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heavenly father." Actions to prevent recurrence included "nurses and CAN's [certified nursing assistants] to monitor more closely for s/s [signs and symptoms] of anxiety and/or pain]." No injury was noted from this fall.

An Incident Report dated 1/4/19, at 11:45 a.m. indicated R1 was found on the floor in the lounge area located by the nurses station. Prior to the fall, R1 had expressed to staff "that little boy, is he ok?" No injury was noted from this fall. Interventions taken to prevent recurrence included taking R1 to the dining area to be with other residents, and staff for closer monitoring and "Broda Chair."

An Incident Report dated 1/5/19, at 3:15 p.m. indicated R1 was found on the floor in the lounge area located by the nurses' station. R1 stated, "I thought I could walk, so I walked and tripped and fell." R1 suffered a 3 centimeter (cm) by 2 cm bruise to her left hand which resulted from the fall. R1 was wearing shoes, and 15 minute safety checks were in effect at the time of the fall. R1 was toileted at 1:15 p.m. and "repositioned self in chair." Actions to prevent recurrence included, "Nursing to ambulate resident when she is restless and allows," in addition to continuing 15 minute safety checks.

A nurses note dated 1/17/19, at 4:37 a.m. indicated R1 was sleeping in her bed at 3:30 a.m. R1 was then found sleeping on the floor at 3:35 a.m. with an afghan under her head and blankets pulled over her. R1 expressed she was trying to sleep when staff approached her. No injuries were noted. An Incident Report dated 1/17/19, at 3:35 a.m. indicated R1 was incontinent of bowel and bladder, and had been checked and changed

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at 2:00 a.m. No injury was noted from the fall.

A nurses note dated 1/26/19, at 8:08 a.m. indicated a nurse heard a noise from R1's room and found her sitting on the floor mat beside her bed. R1 had her incontinent brief off, and it was wet in addition to her gown being wet. The nurses note further indicated staff checked on R1 at 5:15 a.m. No injuries were noted. The facility lacked an Incident Report for this fall.

An Incident Report dated 2/8/19, at 1:45 a.m., indicated R1 was found on the floor next to their bed. R1 was last toileted and repositioned at 1:15 a.m. and noted to be confused and disoriented. Actions taken to prevent reoccurrence included, "Staff to continue Q15 [every 15 minute] safety checks and document on safety form." No injury was noted from this fall.

An Incident Report dated 2/23/19, at 4:40 a.m. indicated R1 was found sliding to the floor from her bed. R1 had one non-skid sock on her foot, and was incontinent. No injury was noted from this incident. The facilities Post Fall Investigation Assessment revealed R1 was last repositioned at 1:30 a.m. and toileted at "start of shift [checked after that]. Further, the Post Fall Investigation Assessment indicted R1's call light was not within reach. Facility actions to prevent reoccurrence included, "Remind and reeducate staff to Q2 [every two hour] toileting and repositioning."

On 2/25/19, at 6:21 p.m. an interview was conducted with family member (FM)-A. FM-A indicated R1 had a fall in June, and broke her hip. FM-A further indicated R1 was sliding out of her wheelchair and had also fallen out of bed.

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On 3/1/19, at 9:38 a.m., an interview was conducted with NA-A. NA-A stated R1 had spurts of energy and wanted to get up. NA-A further stated they attempted to keep R1 from falling by keeping her in activities, used a low bed, and implemented a fall matt. NA-A verbalized when staff heard R1 yelling they needed to provide prompt assistance.

On 3/1/19, at 9:50 a.m., an interview was conducted with licensed practical nurse (LPN)-A. LPN-A stated she believed R1 had one fall. LPN-A was uncertain of the circumstances that surrounded the fall. LPN-A verbalized the facility was doing 15 minute checks on R1.

On 3/1/19, at 10:19 a.m., an interview was conducted with the director of nursing (DON). The DON stated R1 had advanced dementia, was blind, had impaired mobility, and hearing loss which made her a risk for falls. The DON stated R1 suffered a fracture from a fall which occurred last year. The DON stated R1 needed to be in her wheelchair in the lobby area, not be left alone in her room, and toileted and repositioned every two hours to prevent falls. The DON further stated R1 did yell out at times for her husband who was deceased. The DON verbalized the root cause of R1's falls was dementia and confirmed orthostatic blood pressures were not attempted as part of the reassessment of R1's falls.

Copies of R1's progress notes and incident reports from through 1/18 to 7/18 were requested, but not provided by the facility.

R32's Admission Record printed 2/26/19, indicated R32's diagnoses included chronic bronchitis, atherosclerotic heart disease, major

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depressive disorder, mild cognitive impairment, and hypothyroidism.

R32's quarterly MDS dated 12/3/18, indicated R32 had moderate cognitive impairment. R32's MDS further indicated R32 required limited assistance with transfers, and extensive assistance with toilet use. Additionally, 32 was frequently incontinent of urine, always continent of bowel, and did not have any falls.

R32's falls CAA undated, indicated R32 was a fall risk and had a history of falling at home. The CAA further indicated R32 had impaired mobility, and medications included trazadone (antidepressant medication) and ropinirole (medication used to treat restless leg syndrome).

R32's care plan dated 2/26/19, indicated R32 was at risk for falls due to gait/balance problems, incontinence, psychoactive drug use, and recent falls. R32's goal was to be free of falls. Interventions included call light within reach and encourage R32 to use it; nursing to remind R32 to engage wheel chair brakes with transfers; ensure R32 was wearing appropriate footwear and non-skid socks and/or shoes; follow facility fall protocol; and encourage R32 to participate in activities that promote exercise.

R32's care plan dated 2/26/19, further indicated R32 had an activities of daily living (ADL) self-care performance deficit related to pain and impaired mobility. R32's goal was to improve his current level of function in ADLs. Interventions identified R32 was dependent on one staff person, and needed assistance to change his incontinence product as needed, and perineal cares after an incontinent episode.

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R32's Incident/Accident Forms indicated the following falls:

On 9/6/18, at 8:40 p.m. R32 was found on the floor in the men's public restroom. R32 indicated he fell turning the light on. Actions taken to prevent recurrence included putting signage in public restrooms to leave lights on during daytime hours. R32 indicated he had pain in his right shoulder, however, no other injury was noted.

On 12/10/18, at 9:15 p.m. R32 was found on the floor in another resident's bathroom. R32 was noted to be "red faced and breathing hard/wheezing" and his oxygen tank was empty. R32 indicated he attempted using the grab bar, but it did not hold him. Additionally, R32's nasal cannula was twisted beneath him, and his wheelchair was not locked. Actions taken to prevent recurrence included reminding R32 to put wheelchair brakes on when up from his wheelchair. No injury was noted as a result of this fall.

On 12/15/18, at 6:50 a.m. R32 attempted to stand up and turn into his wheelchair. R32 missed the wheelchair, and fell on his bedside table and landed on the floor. R32 complained of severe neck and back pain and was sent to the hospital. The Incident/Accident Form lacked indication of actions taken to prevent recurrence.

On 1/24/19, at 3:00 p.m. R32 was found on the floor in another resident's bathroom. R32 indicated he attempted to turn the light on to use the toilet. Additionally, R32 indicated he attempted to grab a curtain, but forgot they were taken down. Actions taken to prevent recurrence

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included reminding R32 to ask for assistance when he needed to use the toilet. R32 had a laceration to his right hand which resulted from the fall.

On 2/11/19, at 8:05 p.m. R32 was found on the floor in another resident's room. R32 indicated he was attempting to close curtains. Actions taken to prevent recurrence included reminding R32 to ask for assistance when ambulating and a therapy evaluation. R32 had a bruise noted to his left torso as a result of the fall.

On 2/27/19, at 7:25 a.m. R32 was observed sitting in his wheelchair near the nurses' station. R32 verbalized he was having pain in his leg and began to stand. Staff told R32 he was just administered Tylenol and it needed time to work.

On 2/28/19, at 4:08 p.m. R32 was observed self-propelling himself to the men's public restroom using his feet. R32 stated, "Help" numerous times as he was propelling himself. Two staff were standing at the nurses station around the corner from the men's public restroom. R32 began to pull himself up from the wheelchair, using a grab bar, once he was in the men's restroom. The surveyor approached staff and informed them R32 was attempting to self-transfer to the toilet.

On 2/28/19, at 3:25 p.m. an interview was conducted with NA-D. NA-D stated staff needed to keep their eyes on R32. NA-D further stated R32 was up and down, and seemed to be getting harder to care for. NA-D verbalized R32 falls were usually related to him attempting to go to the bathroom without assistance, and stated she caught him attempting to go to the bathroom

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during her shift. NA-D further verbalized R32 had changed a lot cognitively, and he did not understand questions.

On 2/28/19, at 3:33 p.m. an interview was conducted with RN-B. RN-B stated R32 complained of toe pain, did not have the greatest safety awareness, and was prescribed high risk medications which made him a fall risk. RN-B verbalized R32 had a history of falling, and had fallen at the facility recently. RN-B further verbalized interventions to prevent further falls included reminding R32 to call for help. RN-B confirmed R32 experienced forgetfulness.

On 3/1/19, at 10:12 a.m. an interview was conducted with the DON. The DON stated R32's respiratory status, dementia, and overall decline made him a risk for falls. The DON further stated R32 was started on therapy, and sent to see his physician due to a decline the last month. R32's trazadone dosage was reduced, and his prescribed tramadol was discontinued. The DON stated falls mostly occurred when R32 attempted to toilet himself. The DON further stated interventions taken to prevent recurrence included reminding R32 to call for help. The DON did not recall if any interventions related to toileting were taken.

The facility policy Accidents/Falls revised 2/14, directed, "For all residents, a fall risk assessment is conducted upon admission, upon readmission from the hospital, annually, and with any significant change to the resident's status which puts them at a greater risk for falls. Additionally, each resident's fall risk assessment is reviewed on a quarterly basis, and any significant changes in status result in a full reassessment. Further,

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	245138	A. BUILDING _____ B. WING _____	C 03/01/2019

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

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"Any episode of a fall or other incident/accident should be documented on the incident accident report."

R17's Admission Record, printed 3/1/19, indicated R17's diagnoses included gout, dementia with behavioral disturbance, cerebral infarction (stroke), chronic kidney disease, and Alzheimer's disease.

R17's quarterly MDS dated 1/4/19, indicated had severe cognitive impairment. R17's MDS further indicated she required extensive assistance with transfers, had a functional limitation to one upper extremity, and a functional limitation to both lower extremities

R17's care plan dated 3/1/19, indicated R17 was non-ambulatory, required extensive assistance of two staff for transfers, and directed, "Per therapy communication effective 4/27/2018: May use EZ stand and 2 staff to transfer from recliner/wheelchair. Must go SLOW and explain what you are doing."

R17's nursing assistant care sheet, dated 2/28/19, indicated R17 used an EZ Stand (mechanical lift)and two staff to transfer from her recliner to her wheelchair.

On 2/27/19, at 8:46 a.m. R17 was observed being wheeled to her room by NA-E. NA-E exited R17's room, obtained an EZ Stand, and returned to R17's room. NA-E moved the EZ Stand in front of R17's wheelchair, placed a harness behind R17's back and pulled the harness loops under R17's arms towards the front of her body. NA-E connected the harness loops to the EZ Stand and walked towards the front of the EZ Stand and

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F 689	Continued From page 42 placed her hands on its controls. NA-E was asked how many staff were needed to transfer R17. NA-E stated two staff were required, but she was unable to find someone else. The surveyor stopped the transfer at this time. On 2/27/19, at 9:44 a.m. an interview was conducted with NA-F. NA-F stated either one or two people were required to operate the EZ Stand, and it was dependent on the physical therapist's recommendation. NA-F indicated R17 required two staff when the EZ Stand was used. On 3/1/19, at 1:14 p.m. the DON confirmed two staff were required to operate the EZ Stand for R17. The DON stated R17 required two staff for safety due to dementia. EZ Way Smart Stand Operator's Instructions revised 2/16/18, directed, "The EZ Way Smart Stand was designed to be operated safely by one caregiver. However, depending on the situation, facility policy, and the patient's condition, two caregivers may be necessary."	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		4/10/19

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F 690	Continued From page 43 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a catheter drainage bag and tubing were kept off the floor to prevent infections for 1 of 1 residents (R7) reviewed for catheters. Findings include: R7's Admission Record printed 3/1/19, indicated R7's diagnoses included obstructive and reflux uropathy, urethral stricture, urinary retention, chronic kidney disease, and leukemia. R7's care plan initiated 11/6/18, indicated R7 had	F 690	1. R7's catheter drainage bag, tubing and drainage bag cover were changed by the nurse. 2. Other residents identified using catheters have been reviewed to ensure catheter tubing is not in contact with floor. 3. The facility policy and procedure for Catheter-Drainage Bag Change – Closed System has been revised with directions to keep catheter drainage bags and tubing off the floor.	

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F 690	Continued From page 44 an indwelling Foley catheter, with a goal for no signs and symptoms of urinary infections. R7's care plan directed staff to position R7's catheter bag and tubing below the level of the bladder and provide a cover for the bag, and to monitor for signs and symptoms of urinary tract infections. R7's care plan lacked directives to keep the catheter drainage bag and tubing off the floor. R7's progress notes dated 12/8/18, indicated R7 had returned from a hospital stay with a diagnosis of a urinary tract infection (UTI) associated with the indwelling catheter. R7's discharge summary dated 12/8/18, indicated R7 had a UTI and an antibiotic was ordered. R7's progress notes dated 1/30/19, indicated R7 had an emergency room (ER) visit and returned to the facility with a diagnosis of cystitis and orders for an antibiotic. On 2/25/19, at 6:29 p.m. R7's catheter drainage bag was in a privacy bag and was hanging on the side of the bed and touching the floor. On 2/28/19, at 8:12 a.m. R7 was lying in bed, and R7's soiled and stained catheter drainage bag cover was hanging on the right side of the bed, and was touching the floor. R7's catheter tubing was also touching the floor. On 2/28/19, at 8:14 a.m. staff brought in R7's breakfast tray to his room and greeted him. Staff left the room without adjusting the catheter bag. On 2/28/19, at 8:54 a.m. a nurse was in R7's room to administer his medications, then left the room without adjusting the catheter bag or tubing,	F 690	4. Nursing staff have been educated on the revised policy and procedure for Catheter – Drainage Bag Change – Closed System. 5. Audits will be conducted weekly for four weeks, then once a month for two months. 6. DON/Designee will report results and trends of all audits to QAPI Committee for review monthly for 3 months and follow up as needed. 7. Compliance date 4/10/2019.	

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F 690	Continued From page 45 which remained in contact with the floor. On 2/28/19, at 9:24 a.m. licensed practical nurse (LPN)- B verified R7's catheter bag and tubing were touching the floor and should not be, as it increased R7's risk for infection. LPN-B stated R7 has had UTI's and just finished an antibiotic for a UTI. LPN-B changed R7's catheter drainage bag, tubing, and drainage bag cover. On 3/1/19, at 12:59 p.m. director of nursing (DON) verified the catheter drainage bags and tubing needed to be kept off the floor to prevent infections. The facility policy and procedure for Catheter-Drainage Bag Change-Closed System revised 3/14, lacked direction to keep catheter drainage bag and tubing off the floor. The facility policy and procedure for Catheter-Management revised 3/14, lacked direction to keep catheter drainage bag and tubing off the floor.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		4/10/19

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F 695	Continued From page 46 Based on observation, interview, and document review, the facility failed to ensure oxygen tubing was changed as ordered for 1 of 3 residents (R4) reviewed for respiratory services. Findings include: R4's Admission Record printed 2/28/19, indicated diagnoses that included chronic obstructive pulmonary disease, asthma, and anxiety. R4's quarterly Minimum Data Set (MDS) dated 12/7/2018, indicated R4 was cognitively intact, and received oxygen. R4's undated Physician Orders included an order to change oxygen tubing weekly on Wednesdays. The order also indicated to run oxygen at 4 liter per minute (LPM) to keep oxygen saturations greater than 90%. R4's care plan dated 2/27/19, indicated R4 had altered respiratory status/difficulty breathing related to a diagnosis of COPD, asthma and anxiety. The care plan further indicated to provide oxygen via nasal prongs at 4 LPM continuous. On 2/27/19, at 8:40 a.m. R4's oxygen tubing was noted to be dated 1/23/19. R4's February 2019, Treatment Administration Record (TAR) indicated the oxygen tubing was to have been changed on 1/30/19, 2/6/19, 2/13/19, and on 2/20/19, but was not signed off as being completed. On 2/27/29, at 8:49 a.m. licensed practical nurse (LPN)-A verified R4's oxygen tubing had not been	F 695	1. R4 required an extension oxygen tubing added to the end of the nasal cannula oxygen tubing. The nasal cannula tubing has been changes and dated 2/20/2019. The extension tubing had last been changes and dated on 1/23/19. R4 oxygen tubing was changed by the nurse immediately. Review of the resident's TAR showed that the nurse had signed off that the oxygen tubing had been changed on 1/23/19, 1/30/19, 2/6/19, 2/13/19 and 2/20/19. 2. All other residents identified as using oxygen have been reviewed and O2 tubing changed if indicated. 3. Nurses have been educated on the facility policy Infection Control for Respiratory Treatment. Education also included the need to change the entire oxygen tubing set to prevent infection. 4. Audits will be conducted weekly for four weeks, then once a month for two months. 5. DON/Designee will report results and trends of all audits to QAPI Committee for review monthly for 3 months and follow up as needed. 6. Compliance date 4/10/2019.	

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F 695	Continued From page 47 changed since 1/23/19. On 2/28/19, at 2:50 pm. the director of nursing (DON) confirmed the oxygen tubing was dated 1/23/19. The DON stated the facility policy was to change tubing every week, and per MD order. The facility policy Infection Control for Respiratory Treatments dated 3/1/14, directed oxygen tubing would be changed every week.	F 695		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide necessary mental health services during an episode of suicide ideation for 1 of 6 residents (R18) reviewed for behavioral health and mood concerns Findings include: R18's Face Sheet printed 3/1/19, indicated R18 had diagnoses that included major depressive disorder.	F 740	1. Resident 18 was evaluated by his primary care provider. He was started on vilazodone 10 mg by mouth every pm for major depression. Orders were received to re-establish therapy services. He was evaluated on 3/18/19 for therapy services. R 18's Behavior Monitoring Record was updated to include suicidal thoughts and threats of harm to self. R18's care plan was updated with person centered behavioral health interventions.	4/10/19

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F 740	Continued From page 48 R18's quarterly Minimum Data Set (MDS) dated 10/8/18, indicated R18 had intact cognition. On 2/26/19, at 2:29 p.m. R18 was interviewed and stated he had been suicidal, up until maybe a week or two ago. R18 stated the facility never gave offered him to see a physician or therapist about his thoughts of suicide when he reported to them his suicidal thoughts. R18 stated he had seen a therapist for depression, years ago. R18 indicated he wanted to escape (die), but now he has accepted his illness. R18 stated he would still like to see a therapist, and believed it would be helpful for his depression. R18's progress note dated 10/1/18, indicated R18 made statements to staff that he wanted to die. Staff reported to the director of nursing (DON) and administrator. The facility initiated 15 minute checks, and faxed R18's primary MD for treatment of pain and anxiety. The fax identified R18 had behaviors which included insomnia, negative comments, and verbalizing he wishes he would die. The fax lacked identified of R18's thoughts of self-harm or suicidal ideation. A progress note dated 10/18/18, indicated R18 was seen by primary for medication review at which time R18's antianxiety medication was decreased, and an antidepressant was started. The MD note lacked any indication the MD was aware of R18's suicidal thoughts. R18's behavior monitoring records from 10/1/18-2/26/19, lacked indication of suicidal thoughts or thoughts of self-harm as problem behaviors for R18. On 2/26/19, at 2:40 p.m. family member (FM)-A	F 740	2. Other residents reviewed for S/S of worsening depression or indications of threat of harm to self and s/s of worsening depression. 3. Nursing staff have been educated on the proper way to respond to threats of harm to self and signs/symptoms of worsening depression. 4. Audits will be conducted weekly for four weeks, then once a month for two months. 5. DON/Designee will report results and trends of all audits to QAPI Committee for review monthly for 3 months and follow up as needed. 6. Compliance date 4/10/2019.	

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F 740	Continued From page 49	F 740		

stated the facility failed to notify him that R18 had thoughts of self-harm or suicidal ideation. FM-A indicated this was concerning giving R18's history of mental illness and depression. FM-A also indicated there was a family history of suicide, R18's brother had committed suicide, and he would have wanted his father seen by a physician.

On 2/26/19, at 4:38 p.m. the DON was interviewed and verified the fax sent to R18's physician included pain and anxiety. The DON verified the fax did not include R18's thoughts of self-harm or suicidal ideation. The DON further stated it was her belief that R18 had not received counseling since the threats of self-harm were made on 10/1/18.

On 2/27/19, at 10:21 a.m. licensed practical nurse (LPN)-A stated R18 had made the statement of self-harm during morning cares in October. LPN-A stated she immediately reported this to the DON and administrator. LPN-A stated 15 minute checks were started for R18. LPN-A further stated if a resident was threatening to self-harm, an MD should be notified, and the resident sent to the emergency room for evaluation.

On 2/27/19, at 2:18 p.m. the administrator stated he was not aware R18's physician was not informed of his comments of suicide, and stated he should have been informed immediately. The administrator verified R18 should have been offered counseling or therapy services.

The facility's Behavioral Health policy dated 9/22/17, directed residents will receive behavioral health care and services to attain or maintain the

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F 740	Continued From page 50 highest practicable physical, mental, and psychosocial well-being. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.	F 740		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a wheelchair was clean and in good repair for 1 of 1 residents (R34) reviewed for wheelchair cleanliness. Findings include: R34's Admission Record printed 2/28/19, indicated diagnoses that included muscle weakness. R34's quarterly Minimum Data Set (MDS) dated 12/2/2018, indicated R34 was cognitively impaired. R34's care plan dated 8/29/18, indicated R34 had impaired mobility. On 2/25/19, at 6:18 p.m. R34 was observed being brought via wheelchair to the dining room. R34's wheelchair was missing rivets on both sides that attached the back of the wheelchair. In addition, R34's wheelchair cushion was found to be missing a washable cover protector, causing	F 921	1. The back of R34's wheelchair was not missing any rivets nor had it been torn from the frame of the wheelchair. The wheelchair back has rivet rings on the bottom, but they do not attach to the frame of that model wheelchair. The pressure reduction cushion was replaced with a new cushion and cover. 2. An audit of all wheelchairs in use was completed to ensure all pressure reduction cushions have covers. 3. Nursing staff have been educated on infection control and the use of pressure reduction cushion covers. 4. Audits will be conducted weekly for 4 weeks, then once a month for 2 months. 5. DON/Designee will report results and trends of all audits to QAPI Committee for review monthly for 3 months and follow up	4/10/19

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F 921	Continued From page 51 foam to be exposed thus creating an uncleanable surface. On 3/1/19, at 6:18 p.m. R34's wheelchair remained in disrepair. On 3/1/19, at 10:00 a.m. nursing assistant (NA)-C verified R34's wheelchair cushion had only the piece of foam and was not a washable surface. NA-C also verified the back of R34's wheelchair was missing the rivets that secured the back of the wheelchair. NA-C verified R34's cushion had numerous stains from incontinence. On 3/01/19, at 10:04 a.m. the director of nursing (DON) verified R34's verified wheelchair had only the piece of foam and was not a washable surface, and the back of R34's wheelchair was missing the rivets that secured the back of the wheelchair. A policy on wheelchair equipment maintenance was requested but not provided.	F 921	as needed. 6. Compliance date 4/10/2019.	

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K 000	INITIAL COMMENTS	K 000		

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 also has a fire alarm system with smoke detection throughout the corridor system and in the common spaces.

The facility has a capacity of 42 beds and had a census of 39 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is MET.

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.

Electronically delivered
March 18, 2019

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

Re: State Nursing Home Licensing Orders - Project Number S5138030 and H5138021C

Dear Administrator:

The above facility was surveyed on February 25, 2019 through March 1, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5138021C; that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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
	00587	A. BUILDING: _____ B. WING _____	C 03/01/2019

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

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2 000	Initial Comments *****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.	2 000		

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2 000	Continued From page 1 The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 2/25/19 through 3/1/19, 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. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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2 000	Continued From page 2 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.	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; 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	2 265		4/10/19

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2 265	Continued From page 3 resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure notification of the physician and the resident representative regarding a resident's expression of suicidal thoughts for 1 of 4 residents (R18) reviewed for behavioral health and mood concerns. Findings include: R18's Face Sheet printed 3/1/19, indicated R18 had diagnoses that included major depressive disorder. R18's quarterly Minimum Data Set (MDS) dated 10/8/18, indicated R18 had intact cognition. On 2/26/19, at 2:29 p.m. R18 was interviewed and stated he had been suicidal, up until maybe a week or two ago. R18 stated the facility never gave offered him to see a physician or therapist about his thoughts of suicide when he reported to them his suicidal thoughts. R18 stated he had seen a therapist for depression, years ago. R18 indicated he wanted to escape (die), but now he has accepted his illness. R18 stated he would still like to see a therapist, and believed it would be helpful for his depression. R18's progress note dated 10/1/18, indicated R18 made statements to staff that he wanted to die. Staff reported to the director of nursing (DON) and administrator. The facility initiated 15 minute checks, and faxed R18's primary MD for	2 265	Corrected.	

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2 265	Continued From page 4	2 265		

treatment of pain and anxiety. The fax identified R18 had behaviors which included insomnia, negative comments, and verbalizing he wishes he would die. The fax lacked identified of R18's thoughts of self-harm or suicidal ideation.

On 10/18/19, R18 was seen by his MD for medication review. The MD note lacked any indication the MD was aware of R18's suicidal thoughts.

On 2/26/19, at 2:40 p.m. family member (FM)-A stated the facility failed to notify him that R18 had thoughts of self-harm or suicidal ideation. FM-A indicated this was concerning giving R18's history of mental illness and depression. FM-A also indicated there was a family history of suicide, R18's brother had committed suicide, and he would have wanted his father seen by a physician.

On 2/26/19, at 4:38 p.m. the DON was interviewed and verified the fax sent to R18's physician included pain and anxiety. The DON verified the fax did not include R18's thoughts of self-harm or suicidal ideation.

On 2/27/19, at 2:18 p.m. the administrator stated he was not aware R18's family was not notified of his comments of suicide, and stated it was his expectation that the family would be called. The administrator further stated he was not aware R18's physician was not informed of his comments of suicide, and stated he should have been informed immediately.

The facility policy Change in a Resident's Condition or Status dated 3/1/19, directed staff to notify the resident's representative when there was a significant change in the resident's

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2 265	Continued From page 5 physical, mental or psychosocial status, and this notification was to be made within 24 hours. The policy also directed the resident's attending physician or physician on call or nurse practitioner and responsible party will be notified with changes in resident's condition or health status. 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		
2 830	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.	2 830		4/10/19

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2 830	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure compression (TED) socks were provided according to the care plan for 1 of 2 residents (R18) reviewed for quality of care. Findings include: R18's Face Sheet printed 3/1/19, indicated R18 had diagnoses that included hypertension, diabetes mellitus, and atherosclerotic heart disease. R18's quarterly Minimum Data Set (MDS) dated 10/8/18, indicated R18 had intact cognition. R18's Physician Orders dated 2/26/19, indicated R18 was to have TED socks on in the morning and off in the evening daily. On 2/27/19, at 7:59 a.m. R18 was observed in the main dining room, and was not wearing TED socks. On 2/28/19, at 9:04 a.m. R18 was observed sitting in the wheelchair in his room. R18 was not wearing TED socks, and his lower legs were edematous. On 2/28/19, R18's treatment record was reviewed, and indicated staff had been signing that R18 was wearing his TED socks every day in February. On 2/28/19, at 9:17 a.m. nursing assistant (NA)-A stated R18 was to have TED socks on, and they	2 830	Corrected.	

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2 830	Continued From page 7 were part of his care plan. NA-A verified TED socks are on the daily care sheets for the nursing assistants. NA-A indicated R18 has not had the TED socks on for a long time. On 2/28/19, at 9:22 a.m. registered nurse (RN)-A verified R18 was to have TED socks on daily in the morning and off in the evening. RN-A stated R18 was at risk for stroke, and required the physician ordered TED socks. RN-A verified the NA staff have been signing as providing the TED socks for R18 the entire month of February. On 2/28/19, at 2:52 p.m. the director of nursing (DON) stated the expectation was that staff only sign off on cares they had provided. The DON indicated TED socks were important for R18 due to his history of stroke, cardiovascular disease, and edema. The DON stated it was her expectation that all staff are following the care plan and physician orders. A policy for compression stockings and or TED socks was requested, but not received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure the care plan is followed regarding resident's TED socks. 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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2 920	Continued From page 8	2 920		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide routine grooming to remove facial hair for 1 of 4 residents (R32) reviewed for activities of daily living (ADLs) and who was dependent on staff for ADL assistance. Findings include: R32's Admission Record printed 2/26/19, indicated R32's diagnoses included chronic bronchitis, and mild cognitive impairment. R32's quarterly Minimum Data Set (MDS) dated 12/3/18, indicated R32 had moderate cognitive impairment. The MDS also indicated R32 required extensive assistance with dressing, and was independent performing personal hygiene with setup assistance. R32's Care Area Assessment (CAA) undated, indicated R32 had impaired cognition and suffered from mild short-term memory loss. The CAA further indicated staff was to re-orient and cue R32, as needed.	2 920	Corrected.	4/10/19

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2 920	Continued From page 9 During an observation on 2/26/19, at 9:36 a.m. R32 was noted to have stubble on his face. R32 indicated he preferred to be clean shaven, and staff had helped him with this "sometimes." During an observation on 2/27/19, at 11:20 a.m. R32 was sitting in his wheelchair outside of physical therapy. R32 was not shaved and his facial hair appeared to be longer than the previous day. During an observation on 2/28/19, at 8:14 a.m. R32 was observed sleeping, in the dining area, sitting in his wheelchair. R32 was not shaved and his facial hair appeared to be longer than the previous day. During an observation on 3/1/19, at 9:18 a.m. R32 was observed in the dining area sitting in his wheelchair. R32's facial hair appeared longer than previous days. On 2/28/19, at 3:25 p.m. an interview was conducted with nursing assistant (NA)-D. NA-D stated R32 was able to shave independently. NA-D further stated R32 seemed to be becoming more forgetful. On 2/28/19, at 3:57 p.m. an interview was conducted with NA-A. NA-A stated a month ago R32 required setup assistance, however, R32 now required additional assistance with personal hygiene. NA-A further stated R32's ability to shave was "touch and go." On 3/1/19, at 9:20 a.m. a follow-up interview was conducted with R32. R32 again stated he preferred to be clean shaven. On 3/1/19, at 9:38 a.m. an interview was	2 920		

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2 920	Continued From page 10 conducted with NA-B. NA-B stated R32 was starting to require more care. NA-B further stated she was unsure what was happening to R32 cognitively, but he had required additional prompting. NA-B also stated R32 was not making decisions like putting on his shirt, and was having difficulty making "connections." NA-B confirmed R32 was not prompted to shave during the shift. On 3/1/19, at 9:50 a.m. an interview was conducted with registered nurse (RN)-A. RN-A stated R32 required limited assistance with ADLs, however, required prompting to complete tasks. RN-A further stated R32 was cognitively declining, and had visited his physician the prior week and had medication adjustments. On 3/1/19, at 10:12 a.m. an interview was conducted with the director of nursing (DON). The DON stated R32 had an overall decline which was noticeable the last month. The DON further stated R32 required extensive assistance brushing his teeth and shaving. The DON stated the expectation was the resident should be shaved if he wanted it completed. The facility policy Shaving - Safety Razor dated 4/1/18, directed, "Resident will be provided care and services daily which includes shaving as per resident needs and/or care plan." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure ADLs are completed on dependent residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.	2 920		

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2 920	Continued From page 11 The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a wheelchair was clean and in good repair for 1 of 1 residents (R34) reviewed for wheelchair cleanliness. Findings include: R34's Admission Record printed 2/28/19, indicated diagnoses that included muscle weakness. R34's quarterly Minimum Data Set (MDS) dated 12/2/2018, indicated R34 was cognitively impaired. R34's care plan dated 8/29/18, indicated R34 had impaired mobility. On 2/25/19, at 6:18 p.m. R34 was observed being brought via wheelchair to the dining room. R34's wheelchair was missing rivets on both sides that attached the back of the wheelchair. In addition, R34's wheelchair cushion was found to be	21665	Corrected.	4/10/19

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	00587	A. BUILDING: _____ B. WING _____	C 03/01/2019

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21665	Continued From page 12 missing a washable cover protector, causing foam to be exposed thus creating an uncleanable surface. On 3/1/19, at 6:18 p.m. R34's wheelchair remained in disrepair. On 3/1/19, at 10:00 a.m. nursing assistant (NA)-C verified R34's wheelchair cushion had only the piece of foam and was not a washable surface. NA-C also verified the back of R34's wheelchair was missing the rivets that secured the back of the wheelchair. NA-C verified R34's cushion had numerous stains from incontinence. On 3/01/19, at 10:04 a.m. the director of nursing (DON) verified R34's verified wheelchair had only the piece of foam and was not a washable surface, and the back of R34's wheelchair was missing the rivets that secured the back of the wheelchair. A policy on wheelchair equipment maintenance was requested but not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident equipment is in good repair. 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.	21665		

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21840	Continued From page 13	21840		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure Provider Orders for Life Sustaining Treatment (POLST) was completed in accordance with resident preferences for 1 of 3 residents (R22) reviewed for advanced directives. Findings include: R22's Admission Record printed 2/26/19, indicated R22's diagnoses included mild intellectual disabilities, anxiety disorder, chronic kidney disease, major depressive disorder, and unspecified dementia. R22's quarterly Minimum Data Set (MDS) dated 1/21/19, indicated R22 was cognitively intact. R22's Medication Review Report dated 2/26/19,	21840	Corrected.	4/10/19

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21840	Continued From page 14 indicated R22 was a full code resuscitation status (wanted CPR). R22's care plan dated 9/14/17, indicated R22 was a full code resuscitation status. The care plan further revealed R22 had a health care decision maker, and the healthcare decision maker "wishes" for R22 "would be honored ongoing." R22's Honoring Choices Minnesota Health Care Directive was completed by R22 on 5/26/17, and notarized on 5/26/17. The document identified a primary Health Care Agent and directed, "If I cannot communicate my wishes and health care decisions due to illness or injury, or if my health care team determines that I cannot make my own health care decisions, I choose the following person to communicate my wishes and make my health care decisions. My Health Care Agent must: " Follow my health care instructions in this document. " Follow any other health care instruction I have given to him or her. " Make decisions in my best interest." The document further revealed R22's initialed boxes on the health care directive which directed "I want CPR [cardiopulmonary resuscitation] if by heart or breathing stops" and "I want CPR attempted if my heart or breathing stops based on my current state of health. However, in the future if my health has changed; for example; " I have an incurable illness or injury and am dying " I have no reasonable chance of survival if my heart or breathing stops " I have little change of long-term survival if my	21840		

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heart of breathing stops and CPR would cause significant suffering

then my agent or I (if I am able) should discuss CPR with my health care team."

A progress noted dated 7/19/18, at 7:42 a.m. indicated a care conference was held on 7/18/18. The progress note further indicated R22 did not want to attend the care conference per R22's sister, due to an "outburst" that occurred during lunch. The progress note revealed R22's code status was modified to do-not-resuscitate (DNR) / do-not-intubate (DNI) during the care conference.

R22's Provider Orders for Life Sustaining Treatment (POLST) indicated R22 resuscitation status was DNR. The POLST document was signed by R22's Health Care Agent on 7/18/18. The basis for orders section revealed boxes were checked indicating, "HEALTH CARE DIRECTIVE/LIVING WILL," and "BEST INTEREST."

On 2/25/19, at 7:05 p.m. an interview was conducted with registered nurse (RN)-B. RN-B stated the facility used a blue dot system to determine a resident's code status. RN-B further stated if a blue dot was placed on a resident's nameplate outside their room, it indicated CPR was to be performed.

On 2/25/19, at 7:06 p.m., an observation was conducted of R22's nameplate, outside of the room. The nameplate contained a blue dot, which indicated CPR status.

On 2/25/19, at 7:13 p.m., an interview was conducted with nursing assistant (NA)-A. NA-A stated if a resident was found without a pulse they

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21840	Continued From page 16	21840		

would notify the nurse. NA-A further indicated if a blue dot was placed on a resident's room nameplate, it indicated CPR was to be performed.

On 2/25/19, at 7:46 p.m., an interview was conducted with R22. R22 stated if her heart had stopped beating she would like CPR to be performed. R22 further stated she had always wanted CPR performed, and hoped to be around for a long time.

On 2/25/19, 7:54 p.m. an interview was conducted with RN-B. RN-B stated if a resident was found pulseless she would determine a residents code status by checking for a blue dot on the residents nameplate located outside of their room. RN-B further stated she could also check a resident's paper medical record for a blue dot which also indicated to perform CPR.

On 2/25/19, at 8:32 p.m. an interview was conducted with the director of nursing (DON). The DON confirmed the process for determining a residents code status was to check for a blue dot on the nameplate outside of a residents room. The DON also confirmed the POLST for R22 directed DNR. The DON stated R22 had a Health Care Agent who had signed the POLST for R22. The DON further stated she was unsure if any documentation existed declaring the Health Care Agent was authorized to make decisions on R22's behalf. During this time, R22's paper medical record was observed. It lacked a blue dot.

On 2/26/19, at 8:40 a.m. the blue dot located on R22's nameplate outside her room was observed to be removed.

On 2/26/19, at 10:22 a.m. an interview was

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conducted with licensed practical nurse (LPN)-A. LPN-A stated if a resident was found pulseless, she would check the resident nameplate for a blue dot. LPN-a further indicated she would check a resident's paper medical record if a resident experienced a cardiac arrest in the commons area as it was in closer proximity.

On 2/26/19, at 10:27 a.m. an interview was conducted with the DON. The DON verbalized a care conference was held with R22's Health Care Agent, and it was decided to R22's change R22's code status to DNR. The DON further verbalized the appointed Health Care Agent was R22's Health Care Power of Attorney. The DON stated she was unsure if R22 was deemed incapable of making her own health care decisions. The DON further stated she was unsure if R22's Health Care Agent had a discussion with R22 regarding the change in code status. The DON confirmed she had removed the blue dot from R22's nameplate.

On 2/26/19, at 10:36 a.m. an interview was conducted with social worker (SW)-A. SW-A stated R 22 was cognitively intact, and knew what she wanted to do. SW-A further stated she believed residents should be aware of decisions made in a care conferences when they were not present.

On 2/26/19, at 2:38 p.m. an interview was conducted with the administrator. The administrator verbalized residents should be involved in discussions regarding their resuscitation status, if able. The administrator confirmed if staff would had looked at the POLST, R22's wishes would not have been followed. The administrator also confirmed the facility should have talked to R22 about her resuscitation

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wishes. The administrator also stated the facility should assess a resident's ability to make health care decisions if it was felt a resident was not competent to do so. The administrator was not aware the blue dot from R22's room was removed.

On 2/26/19, at 3:04 p.m. a follow-up interview was conducted with the DON. The DON stated the blue dot was removed from R22's room nameplate because R22's POLST directed DNR status. The DON verbalized R22's resuscitation status was changed to DNR because her Health Care Agent made the decision. The DON stated she was unaware if R22 was deemed incapable of making health care decisions, and confirmed the facility lacked documentation which indicated R22 was incapable of making health care decisions.

On 2/26/19, at 4:35 p.m. a follow-up interview was conducted with R22. R22 described CPR as, "When they press on your chest to get your heart beating," and they breathe for you. R22 again confirmed she wanted CPR performed.

On 2/26/19, at 4:50 p.m. a blue dot was observed on the nameplate outside R22's room. Additionally, an updated POLST directing CPR was signed by R22.

On 2/28/19, at 10:29 a.m. a follow-up interview was conducted with the Administrator and SW-A. SW-A indicated R22 usually refused to attend care conferences and R22's Health Care Agent attended the meetings. The Administrator indicated R22 was able to say what she wants, but also changed her mind a lot. SW-A indicated R22's cognition was fine. The Administrator verbalized if a residents code status was

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changed, without their knowledge, the facility should check with the resident to ensure they were okay with it. SW-A also confirmed a resident should be involved in decisions about their care when they chose not to attend care conferences.

R22's medical record lacked indication she was incapable of making heath care decisions.

The facility policy Cardiopulmonary Resuscitation (CPR) revised 11/16, directed each resident's CPR preference will be expressed in Advance Directive documents such as a living will, a Power of Attorney for Health Care Document, or a CPR preference form. The policy further directed, "The right to formulate an advance directive applies to each and every individual."

The facility policy Advance Directives and Rights Regarding Treatment revised 11/16, directed, "The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive." The policy further directed, "The community promotes these rights by:

" Informing and educating the resident about these rights and the community's policies regarding exercising these rights;
" Helping the resident to exercise these rights; and
" Incorporating the resident's choices regarding these rights into treatment, care and services"

The policy also directed, "The community will periodically assess the resident for decision making capacity and invoke the health care agent or legal representative if the resident is determined not to have decision-making capacity

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21840	Continued From page 20 (according to state law or process)." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents resuscitation preferences are honored. 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.	21840		