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	01/25/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 45842 Based on interview and document review, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) to 2 of 3 residents (R17, R137) reviewed whose Medicare Part A coverage ended while in the facility. Findings included: R17's Notice of Medicare Non-Coverage (CMS-10123), dated 11/15/23, indicated R17's last day of skilled services was on 11/17/23. The form was signed by resident representative (RR) and dated 11/15/23. In addition, R17's Advance Beneficiary Notice of Non-Coverage (ABN; CMS-R-131) had been provided which indicated a potential cost of over $329.48 / day to R17 if paying privately for care and services at the facility. However, R17's medical record lacked evidence the required CMS-10055 had been reviewed and/or provided to R17 prior to their Medicare Part A coverage ending. R137's Notice of Medicare Non-Coverage (CMS-10123), dated 1/10/24, identified R137's last day of skilled services was on 1/12/24. The form identified R137 signed on 1/10/24. In addition, R137's Advance Beneficiary Notice of Non-Coverage (ABN; CMS-R-131) had been provided which identified a potential cost of $418.65 / day to R137 if paying privately for care and services at the facility. However, R137's medical record lacked evidence the required CMS-10055 had been reviewed and/or provided to R137 prior to their Medicare Part A coverage ending. During an interview on 1/23/24 at 3:53 p.m., social services designee (SSD) stated she was responsible to ensure the CMS-10123 and subsequent appeal notices, including the CMS-10055, were provided to residents. SSD reviewed R17's and R137's census reports and stated each resident had been covered with only Medicare Part A coverage and transitioned to a different payer source when their coverage was ended when the SNF determined they would no longer qualify for coverage. The SSD verified the CMS-10055 was not provided to R17 and R137. The SSD stated CMS-10055 was used up till 6 months ago when corporate staff told the facility to change to the CMS-R-131. The facility's policy titled Notice of Medicare Non-Coverage, was requested but not provided.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47263 Based on observation, interview, and record review the facility failed to ensure the electronic medical record (EMR) was secured in a manner that prevented unauthorized individuals from viewing and or accessing confidential resident information contained within the EMR. This had the potential to affect all 31 residents residing at the facility. Findings include: During an observation on 1/24/24 at 8:33 a.m., trained medication aide (TMA)-A walked away from the medication cart located in the hallway. The EMR was open and displayed resident information. TMA-A assisted another staff access a storage room around the corner and then returned to the medication cart. During a continuous observation on 1/25/24 at 8:22 a.m., the medication cart in the hallway was unattended and the EMR was open and displayed a resident's medication list. - 8:25 a.m., the cart was unattended and the EMR continued to display resident information. - 08:29 a.m., no change, multiple staff walked by the medication cart and did not notice the open EMR. - 8:31 a.m., TMA-A exited a resident room, stopped at cart, looked at screen, left EMR open, left cart unattended, and entered another resident room. -8:34 a.m., TMA-A returned to the medication cart. During an interview on 1/25/24 at 8:34 a.m., TMA-A acknowledged that they had left the EMR open and unattended. TMA stated it was easy to lock the screen and demonstrated how to lock and unlock the EMR with a few clicks. TMA-A stated the EMR needed to be locked for resident privacy and confidentiality and confirmed they should have locked the EMR when they stepped away from the medication cart. The EMR should be locked every time we step away from the medication cart. During an observation on 1/25/24 at 9:57 a.m., the EMR on the medication cart in the hallway was noted to be unattended and displayed a resident's name and medication administration information. TMA-A exited a resident room from down the hallway and returned to the medication cart. During an interview on 1/25/24 at 10:52 a.m., the director of nursing (DON) stated to be in compliance with HIPAA [Health Insurance Portability and Accountability Act (a federal law that restricts access to individuals' private medical information)], resident information needed to be protected and secured. The DON explained that their EMR had a built-in lock feature designed to secure their EMR and prevent unauthorized access or viewing of confidential resident information. The DON stated they expected staff to lock or close the EMR every time they stepped away from the EMR, no exceptions. This had the (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy Privacy and Confidentiality dated 11/2016, identified residents had the right to have privacy and confidentiality of their personal and medical rights and their information would be safeguarded at all [NAME] to ensure confidentiality.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on interview and document review, the facility failed to ensure provider orders to monitor blood pressure were followed for 1 of 5 residents (R3) reviewed for unnecessary medications. Findings include: R3's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and diagnoses of essential hypertension, history of cerebral vascular attack (CVA), and schizoaffective disorder. R3's care plan dated 3/22/18, identified the potential for medication side effects including hypotension (low blood pressure) with an intervention to monitor for orthostatic hypotension (low blood pressure upon standing). R3's provider orders dated 4/8/21, identified an order for orthostatic blood pressure readings (one reading taken while seated and one minute later a reading taken after standing) to be taken on R3's shower day every 28 days and to make a progress note if not obtained. R3's electronic health record did not reflect orthostatic blood pressure readings or notes regarding why it was not obtained. During an interview on 1/24/24 at 1:47 p.m., the director of nursing (DON) stated she would expect the orthostatic blood pressure to be done if as ordered, and it was important because R3 took medication which may cause hypotension and they needed to track this because it (orthostatic hypotension) put R3 at risk for falls. A facility policy, Physician's Order - Recording dated May 2020, did not address expectations with following a provider order.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49878 Based on observation, interview and document review, the facility failed to follow provider interventions for wound care for 1 of 2 residents (R8) reviewed for pressure ulcers. Findings include: R8's quarterly Minimum Data Set (MDS) dated [DATE], identified R8 as moderately cognitively impaired, was dependent on staff for transfers and repositioning, and had lower extremity impairment. R8's diagnoses included multiple sclerosis (autoimmune disease in which the insulating covers of nerve cells are damaged), functional quadriplegia (weakness or paralysis leading to partial or total loss of function in the arms, legs, trunk and pelvis), nondisplaced transverse fracture of shaft of right tibia (bone fracture of the tibia in right leg), heart disease, diabetes mellitus, and an unstageable pressure injury on the right foot. R8's care plan dated 1/2/24, identified R8 was at risk for impaired skin integrity including skin tears, bruising, and/or pressure injury. Intervention instructed staff to float R8's heel with boots or pillows on all sides of heels. Further, it instructed staff to check R8 for boots or pillow use on rounds and when needed. R8's care plan further identified R8 to have heel protectors on while in bed. Care guide dated 1/24/24, identified R8's heels must be floated at all times when in bed and heel boots worn for pressure reduction when in bed. Physician order dated 5/4/23, instructed staff to turn and reposition R8 twice on day and evening shifts and once during night shift. Order also stated any refusals by R8 should be documented in the chart. Physician order dated 11/21/23, ordered nursing staff to apply green protective boots on R8 whenever in bed. Orders further instructed nursing staff to document when boots are on or off R8. Physician order dated 12/15/23, medical doctor (MD) placed cast on R8's lower right leg and foot. Physician order dated 1/2/24, instructed nursing staff to check R8's right heel cutout spot for drainage. Provider progress note dated 1/2/24, MD identified blanchable red spot 7 centimeters (cm) in diameter on R8's right knee and ulceration 2 cm in diameter on resident's right heel. MD identified R8's cast to have cutouts over areas of concern on resident's right knee and right heel. MD instructed nursing staff to float R8's heel to take pressure off the heel. Progress note dated 1/16/24 at 3:16 p.m., identified interdisciplinary team (IDT) discussed R8's pressure injury on right heel. IDT identified cutouts on cast as appropriate treatment and that R8's heels should be floated when lying in bed and continue to use pressure relief boot on R8's left foot. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/24 at 11:19 a.m., R8 observed to be lying in bed. R8's right foot in a splint, on a pillow and not floated. Heel protector observed to be on chair in R8's room. On 1/24/24 at 7:17 a.m., continuous observation began with the following observed: -At 7:17 a.m., R8 was lying in bed with the door open and lights off. No staff observed to go into R8's room. -At 7:31 a.m., R8 was lying in bed with the door open and lights off. No staff observed to go into R8's room. -At 7:59 a.m., R8 was lying in bed with the door open and lights off. No staff observed to go into R8's room. -At 8:30 a.m., R8 was lying in bed with the door open and lights off. No staff observed to go into R8's room. -At 8:43 a.m., activities assistant (AA)-A brought in breakfast tray to R8. AA-A placed breakfast tray on bedside table, and moved table closer to R8. AA-A did not offer to reposition R8. Heel protectors observed to be on chair in R8's room. An unidentified nurse entered the room and was observed moving R8 up towards head of bed. Unidentified nurse did not remove blanket from R8's legs, and did not check to see if R8 had heels floated or if wearing heel protectors. Heel protectors continued to be on chair in R8's room. On 1/24/24 at 9:04 a.m., AA-A entered R8's room to give menu to resident. AA-A turned on television at R8's request. AA-A did not offer to reposition R8. Heel protectors continued to be on chair in R8's room. On 1/24/24 at 9:24 a.m., AA-A and registered nurse (RN)-A entered R8's room. RN-A uncovered R8's legs and saw their heels were not floated. RN-A administered heel protectors and a pillow to float R8's heels. During interview on 1/24/24 at 9:30 a.m., RN-A confirmed R8's legs were flat on the bed when she went into R8's room. RN-A stated R8's heels should always be floated and checked during every interaction with R8. RN-A further stated the expectation was R8's heels should be floated when in bed, and it was important to do so to promote healing of pressure injury. During interview on 1/24/24 at 9:45 a.m., nursing assistant (NA)-C confirmed R8's heels should be floated at all times when in bed. NA-C also confirmed R8's legs were flat on the bed that morning. During interview on 1/24/24 at 10:05 a.m., director of nursing (DON) expected staff to float R8's heels to promote healing and prevent further damage. DON also expected staff to reposition R8 every 2-3 hours. DON stated staff should notify nurse when R8 refuses cares and refusal should be documented in R8's chart. During interview on 1/24/24 at 10:46 a.m., physician stated they expected nursing staff would follow orders for R8 and float heels when in bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pressure Ulcer/Skin Integrity policy dated 4/2022, identified facility will ensure a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from forming.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49878 Based on observation, interview and document review, facility failed to ensure staff properly utilized a total body mechanical lift for 1 of 2 residents (R15) reviewed for accidents. Findings include: R15's quarterly Minimum Data Set (MDS) dated [DATE], identified R15 was severely cognitively impaired, required substantial assistance with activities of daily living (ADLs), and was dependent on staff for transfers. R15's diagnoses included Parkinson's disease (progressive disease of the nervous system), heart disease, and dementia (progressive or persistent loss of intellectual functioning). R15's care plan dated 1/8/24, identified R15 required use of a total body mechanical lift for transfers with assist of two staff. R15's care guide dated 1/24/24, identified R15 required use of Hoyer lift (manufacturer of mechanical lifts) with an assist of two staff. On 1/24/24 at 9:01 a.m., nursing assistant (NA)-A was observed pushing R15 in wheelchair to resident's room. NA-A left R15 in room and brought a total body mechanical lift into R15's room. NA-A closed R15's door. No other staff were observed to enter or exit room. On 1/24/23 at 9:20 a.m., NA-A was observed to bring mechanical lift out of R15's room. NA-A pushed R15 in wheelchair out of resident's room and brought resident to the lounge. No other staff were observed to enter or exit room during this time. During interview on 1/24/24 at 9:21 a.m., NA-A stated he brought R15 to their room to complete ADLs. NA-A confirmed he used the total body mechanical lift to transfer R15 to bed and back to wheelchair. NA-A volunteered he should have had another staff to help with lift. During interview on 1/24/24 at 12:07 p.m., NA-A stated he was not sure on the policy for safely transferring residents with total body mechanical lifts. NA-A further stated he felt confident in his abilities to safely transfer residents without the help of other staff. During interview on 1/24/24 at 2:30 p.m., NA-B confirmed two staff were needed to use the total body mechanical lift with residents. During interview on 1/25/24 at 9:13 a.m., director of nursing (DON) stated the training for use of total body mechanical lifts included videos of proper technique and demonstration of safe use. DON stated staff were expected to use two staff when using a total body mechanical lift to transfer a resident. Mechanical Lifts (Total Body & Sit-to-Stand) policy dated 11/2022, indicated a minimum of two staff will be used to operate all mechanical lifts at all times.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47263 Based on observation, interview and document review the facility failed to ensure residents were offered proper hand sanitization prior to meals. This had the potential to impact all residents that consumed meals in the dining room. Findings include: During a continuous observation of the dining room on 1/24/24 from 8:26 a.m., to 9:26 a.m., residents were seated at three tables. Each resident was offered a clothing protector and assistance with meal setup and or consumption as needed. However, there were no observations of staff offering or of resident's hands being sanitized prior to meal consumption. The main entrance to the dining room had a sign on the door that read be a germ buster wash your hands. Staff observed to be assisting residents during this time included nursing assistant (NA)-A, NA-B, NA-C, NA-D, and activities aide (AA)-A and AA-B. During a continuous observation on 1/24/24 12:05 p.m., to 12:51 p.m., residents were seated at four tables. There were no observations of residents already seated in the dining room or being brought into the dining room being offered to have their hands sanitized. Staff observed to be assisting residents during this included nursing assistant (NA)-A, NA-B, NA-C, NA-D, (AA)-A and AA-B and kitchen staff that assisted with passing beverages and food to residents. During a continuous observation on 1/25/24 from 8:19 a.m. to 8:40 a.m., there was a large pump bottle of hand sanitizer located by the sink staff used to wash their hands. Staff offered residents clothing protectors but did not offer residents the opportunity to sanitize their hands prior to eating their meal. Staff observed to be assisting residents during this time included (NA)-A, NA-B, NA-C, NA-D, (AA)-A, and the physical therapist assistant (PTA)-D. During an interview on 1/25/24 at 10:13 a.m., NA-D-stated they did not help residents sanitize their hands before meals because they were never taught to do that before meals during their orientation. NA-D indicated it would be important for residents to have their hands sanitized before eating to prevent the spread of germs and for good hygiene. During an interview on 1/25/24 at 10:32 a.m., NA-B confirmed they had not been helping residents sanitize their hands before meals during meals, but indicated normally staff did offer hand sanitizer to residents before meals. It was important for residents to sanitize their hands before they ate for infection control. During an interview on 1/25/24 at 10:41 a.m., the director of nursing (DON) stated residents should be offered an opportunity to have their hands sanitized before they eat meals. The sanitization of hands is important for infection prevention and control. The facility policy Handwashing dated 11/2022, did not address resident hand sanitization. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Dining and Food Service dated 10/2022, instructed staff Prior to eating, assess resident's appearance at meals for hygiene issues as needed, but did not include instruction for resident hand sanitization prior to meals.