STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boundary Waters Care Center	200 West Conan Street Ely, MN 55731

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0580

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45842

Based on observation, interview, and document review the facility failed to notify the provider of a resident presenting with mentation and respiratory changes for 1 of 1 residents (R6) reviewed for change in condition.

Findings included,

R6's Quarterly Minimum Data Set (MDS) dated [DATE], identified R6 had moderate cognitive impairment. Diagnoses included coronary artery disease, cerebrovascular accident (CVA), chronic obstructive pulmonary disease (COPD) and respiratory failure. The MDS indicated R6 was not comatose. R6 could also hear adequately without hearing aides, speak clearly, and usually understood others.

R6's care plan, last revised [DATE], identified respiratory concerns but lacked notification to provider for intervention changes.

R6's provider signed Minnesota Provider Orders for Life-Sustaining Treatment (POLST), dated [DATE] indicated under section A- Cardiopulmonary Resuscitation (CPR) R6 was a do not attempt resuscitation (DNR). It also indicated under section A when not in cardiopulmonary arrest (the heart and or lungs have stopped working), follow orders in section B. Section B -Medical Treatments R6 had Selective Treatments chosen. Selective Treatments included use medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. Also may consider less invasive airway support and transfer to hospital if indicated, but to avoid intensive care units.

On [DATE] at 3:18 p.m., R6 was observed laying in bed with the head of bed at a 90 degree angle. Respirations were deep and labored and moisture could be heard in her airway as she took breaths and when she coughed. R6 was observed staring forward and not responding to verbal questions, requests, and was not tracking where the voices were coming from.

R6's medical record was reviewed and identified the following:

- On [DATE], R6 was discharged from hospice since her condition had been very stable and steady. R6 responded to commands, cooperative and follows directions. Assessment indicated lungs were clear but diminished in the bases. Hospice staff had interviewed staff and documented R6 had no cough and had been alert.

(continued on next page)

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On [DATE] at 1:13 p.m., MDS interview completed with R6 and staff and R6 answered questions appropriately and understood directions with cares when given. There was shortness of breath when laid flat but not with transfers. - On [DATE] at 9:09 a.m., family called to advise of change in R6's breathing and increased lethargy. - On [DATE] at 11:24 a.m., daughter called to speak with R6. Held phone up to ear because R6 was unable to communicate. Family in route as soon as able. During interview on [DATE] at 6:30 p.m., licensed practical nurse (LPN)-A stated anytime a resident had a change of condition the family, director of nursing (DON) and the provider would be notified of a change of condition. If the person was on hospice, then hospice would be notified along with the provider. LPN-A stated that at 9:00 a.m. R6 became more lethargic and had changes in her respiratory system. Breathing was labored, deep, and there was audible moisture heard when she was breathing. R6 did eventually lose ability to communicate. She called R6's family members and the DON and reported the change of condition to them. She stated she did not notify the provider of the change of condition and had not been advised to call the provider. LPN-A stated family had asked if R6 should be sent to the emergency room and was told it was not needed. LPN-A did acknowledge there was a significant change in R6's condition. During interview on [DATE] at 10:50 a.m., registered nurse (RN)-A stated that changes in mentation and respiratory system issues would be considered a change in condition, especially if the patient had been stable prior to the incident. Any change of condition would result in the family, provider, and DON being notified so a plan of care could be made to address the changes. RN-A stated code status would not affect the decision to notify the provider. During interview on [DATE] at 11:48 a.m., the DON stated that a change of condition was based on each individual case. If a change of condition did occur the expectation would be the nurse notify the family, provider, and myself [DON] of the change. The DON stated that even if the resident was DNR the provider would still be notified of the change. Facility policy Notification of Change, last reviewed ,d+[DATE], indicated the staff would consult the resident's physician, nurse practitioner, or physician assistant and notify the resident representative or an interested family member when there was an acute illness or a significant change in the resident's physical, mental or psychosocial status. Examples were deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications. Life-threatening conditions would include but were not limited to such things as heart attack or stroke.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49877 Based on interview and record review the facility failed to assess, monitor, and implement interventions to prevent decreased range of motion (ROM) for 1 of 4 residents (R5) reviewed for positioning, mobility, and ROM. Finding include: R5's quarterly Minimum Data Set (MDS) dated [DATE], identified R5 was cognitively intact and had functional range of motion (ROM) impairment of the right and left upper extremities (shoulder, wrist, and/or hand). R5 requires partial to moderate assistance for upper body dressing and was dependent on staff to for personal hygiene. During the assessment period (9/10/24 to 9/17/24) R5 did not receive physical therapy (PT), occupational therapy (OT), or restorative nursing services. R5's OT evaluation and plan of treatment dated 4/11/23, identified R5 did not have functional limitations due to a contracture (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity, rigidity of joints, and reduced ROM). During interview on 10/13/24 at 3:25 p.m., R5 stated she has had ROM impairment in her left hand for at least 3 years. R5's fingers on her left hand were curled into, and touching her palm. R5 stated she was unable to extend/open her fingers and would be willing to work with PT, OT, and/or restorative nursing to improve/maintain the ROM in her left hand if it was offered. During interview on 10/14/24 at 3:14 p.m., COTA-A confirmed R5's last OT evaluation was on 4/11/2023. At that time, R5 was referred for weakness and the goal of therapy was to improve transfer ability. R5 was discharged from OT on 5/4/23 and has not received PT/OT services since. During interview on 10/15/24 at 12:26 p.m., occupational therapist registered (OTR)-A confirmed she had completed R5's OT evaluation on 4/11/23 and the evaluation identified R5 did not have a contracture. OTR-A stated at the time of the evaluation, R5 had tightness in her left hand and then used her hand to demonstrate that R5's fingers were curled in an opened C shape. OTR stated she re-evaluated R5 today (10/15/24), noted R5's left hand fingers were now folded into her palm, and determined R5's left hand was contracted. OTR-A explained rehabilitation therapy services do not routinely screen for changes in ROM or the development of contractures. The facility process was for nurses to monitor for changes in ROM and the development of contractures and to report these changes. Reported changes would result in a PT/OT evaluation. OTR-A states since discharge on 5/4/23 and up until today (10/15/24) she was not notified of any changes in R5's ROM or contracture development. During interview on 10/15/24 at 1:56 p.m., registered nurse (RN)-A stated it was the responsibility of nursing staff to monitor and report any change in resident condition which included the development of a contracture. During interview on 10/16/24 at 10:28 a.m., RN-B stated all nurses are trained and expected to monitor and report any change in ROM which included the development of a contracture. When a change in ROM was reported, a PT/OT referral would be made, and a PT/OT evaluation would be completed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/16/24 at 11:23 a.m., the administrator stated it was important to report contractures so steps can be taken to prevent further decline or impairment. Facility policy Restorative Program last revised 5/20, indicated while in this facility, all residents are supported to maintain or attain their highest level of functioning. Further, all residents are assessed upon admission and at each care plan meeting for possible inclusion in restorative programs.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on observation, interview, and document review, the facility failed to ensure oxygen tubing was changed according to facility policy as well as failed to ensure nebulizer tubing/canisters were cleaned and allowed to air dry after each use for 1 of 1 resident (R21) reviewed for oxygen therapy. Findings include: R21's annual Minimum Data Set (MDS) dated [DATE], identified R21 was cognitively intact and had continuous oxygen therapy. Diagnoses included chronic obstructive pulmonary disease (COPD). R21's provider order dated 12/28/23, identified orders to change oxygen tubing and nebulizer tubing weekly on Saturday night. Provider orders dated 6/20/23, identified Ipratropium-Albuterol Inhalation Solution 0.5-2.5 milligram(mg)/3 Milliliters (ml) (a respiratory medication utilized to treat COPD). 3ml inhale orally every 4hr for COPD while awake. Provider orders dated 8/29/24 indicated oxygen 2-4 liters(L) continuous. R21's care plan undated, identified R21 needed continuous oxygen therapy and to administer oxygen and respiratory medications as per orders. The care plan lacked documentation when to change oxygen tubing and when/how to clean nebulizer tubing/canister. R21's treatment administration record for 10/24, indicated oxygen tubing and nebulizer tubing had been changed on 10/5/24, but not 10/13/24. On 10/13/24 at 3:42 p.m., R21 was observed wearing continuous oxygen via nasal cannula. The date on the green extension tubing and the nasal cannula could not be located. An undated nebulizer canister and tubing were observed sitting on the chest. The canister was noted to be closed and had visible liquid in the canister along with condensation along the inner walls of the canister. The mask was covered with dried items and moisture stained. During interview on 10/13/24 at 3:44 p.m., R21 stated the staff occasionally change the oxygen tubing, nebulizer tubing, and canister the way they were supposed to and R21 could not remember when it was last changed. The staff will never clean out the nebulizer canister after my treatment. They bring me the medication and I give myself the treatments and staff is supposed to clean the nebulizers. I give myself my first nebulizer treatment around 7:00 a.m. and they are every 4 hours after that. On 10/15/24 at 10:17 a.m., the oxygen tubing and nasal cannula were observed, and a date could not be found. The tubing on the nebulizer was noted to have date 10/14/24, taped on it. The nebulizer canister was noted to have visible liquid inside the closed canister, as welll as condensation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/15/24 at 10:50 a.m., registered nurse (RN)-A stated all oxygen tubing and nebulizer tubing/canisters would be changed every 7 days on Saturday night. Documentation of the change would be done in the TAR and the tubing would be labeled with tape and the current date on the tape. RN-A stated nebulizer canisters needed to be cleaned after each use and allowed to air dry in separate pieces before the next treatment was given. Cleaning should occur immediately after the medication in the nebulizer was administered. RN-A entered R21's room and looked at the nebulizer tubing and confirmed a date of 10/14/24 was written on tape and placed on the nebulizer tubing. RN-A then looked at the green extension tubing and nebulizer tubing and found a faded date written directly on both tubing of 9/14. RN-A also confirmed 9/14 was a Saturday in 2024 and the writing style was different than the nasal cannula and nebulizer tubing. RN-A also confirmed the nebulizer had not been cleaned out since the last treatment had been taken. During interview on 10/16/24 at 10:38 a.m., RN-B stated all oxygen tubing and nebulizer tubing/canisters should be changed every 7 days, on Saturday night. RN-B stated nebulizer canisters should be cleaned immediately after each use to prevent bacteria growth that can occur with left over moisture in the canister. During interview on 10/16/24 at 11:48 a.m. the director of nursing (DON) stated staff were expected to change the nebulizer tubing weekly and clean nebulizer canisters after each use. Facility policy Nebulizer Treatment last revised 4/09, indicated after each use staff should disconnect nebulizer tubing, shake out excess liquid, allow the nebulizer cup to air dry and then place the dry nebulizer in a clean plastic bag. Nebulizer and tubing should be replaced every 7 days. Facility policy Oxygen Administration last revised 2/23, indicated the oxygen tubing needed to be replaced weekly and as needed.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 49877 Based on interview and document review, the facility failed to ensure a nutrient and/or calorie substantive snack was offered and provided after the evening meal and before bedtime. This had the ability to affect all 32 residents who reside within the facility. Findings include: During interview on 10/14/24 at 10:30 a.m., cook (C) stated mealtimes are 8 a.m., noon, and 5 p.m. and the facility does not prepare or distribute a bedtime snack cart. During interview on 10/14/24 at 11:06 a.m., licensed practical nurse (LPN)-A stated a bedtime snack pass does not occur. Snacks such a pudding, chips, cookies, and sandwiches are always available, but not offered. If a resident wants a snack, they need to ask for one. During interview on 10/14/24 2:08 p.m. nursing assistant (NA)-A stated a bedtime snack pass does not occur and if a resident wants a bedtime snack, they need to ask for one. Not all residents ask for a bedtime snack. During interview on 10/15/24 8:55 a.m., culinary director (CD) confirmed mealtimes are 8 a.m., noon, & 5 p. m. and snacks are available, but not offered at bedtime. CD stated it was important to offer a bedtime snack to maintain resident nutrition and caloric needs. During resident council interview on 10/15/24 at 1:25 p.m., residents stated a bedtime snack was not offered and they were unaware snacks were available in the evening. During interview on 10/16/24 at 11:20 a.m., administrator confirmed there was greater than 14 hours between meals and a nourishing snack was not served at bedtime. It was important to offer a bedtime snack to the residents to maintain their nutrition. Facility policy, Meal Frequency dated 11/2002, identified there will be no more than 14 hours between a substantial evening meal and breakfast the following day, expect when a nourishing snack is served at bedtime. A snack is to be offered to all residents at bedtime.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on observation, interview and record review, the facility failed to provide physical therapy and occupational therapy as ordered for 1 of 1 resident (R30) reviewed for therapy services. Findings include: R30's Admission Record undated, identified R30 was admitted from another long-term care (LTC) facility on 5/7/24, Diagnoses included acute infarction of spinal cord and paraplegia. R30's quarterly Minimum Data Set (MDS) dated [DATE], identified R30 had intact cognition and did not exhibit behavioral symptoms. The MDS identified R30 had impairments to both lower extremities, could not ambulate, and needed maximal assistance for transfers. R30's discharge instructions and summary from R30's former LTC facility, dated and signed 5/6/24, identified R30 was discharged to Boundary Waters Care Center. Instructions included under section F-Activity/Therapy/Current Mood/Behavior part B indicated orders for therapy for transfers to another facility included PT to OT. The orders lacked documentation orders were only for a decline or change in condition. The Active Order Summary Report from R30's former LTC facility, dated and signed 5/6/24, was included in the discharge/admission instructions and included PT/OT to evaluate and treat. Those orders also lacked documentation to do only if there was a change of condition or decline. During interview on 10/13/24 at 7:12 p.m., R30 stated the facility had never evaluated for either occupational or physical therapy. During interview on 10/14/24 at 11:08 a.m., certified occupational therapy assistant (COTA)-A stated when any resident was admitted or transferred into the facility, orders were reviewed to see if they had therapy orders or qualified for therapy orders. If there were therapy orders the physical therapist and/or occupational therapist would do an evaluation. If no order, then the ID would do a screening to see if they qualified for therapy. The ID stated she had reviewed R30's admission paperwork and was aware of therapy orders from 5/6/24. COTA-A stated the inter-departmental team discussed the referrals and felt it was not appropriate since the resident had been evaluated for hospice and was thinking about it. If R30 had decided against hospice the nursing was to notify therapy department so the evaluations could be done. The therapy department never requested orders to cancel or postpone the PT/OT evaluate and treat orders that arrived on admission. COTA-A did acknowledge R30 was at increased risk of contractures and other declines due to not following orders and having PT/OT evaluate and treat. R30's discharge instructions and summary and active order summary report dated and signed 5/6/24, were reviewed and lacked any orders for hospice or hospice consult. R30's referral forms dated 4/25/24, sent to the facility to review to accept transfer lacked any documentation related to hospice referral or orders. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's C-Fast Form-Clinical Fast Approval Screening Tool, last reviewed 2/26/24, included R30's medical information. The form lacked any indication there was a hospice referral. During an interview on 10/16/24 at 10:53 a.m., registered nurse (RN)-A stated the IDT team had been aware of R30's admission orders upon arrival but thought he was going on hospice, so they had not been followed through on. A few days following admission, R30 decided not to seek hospice. The therapy department was not made aware of R30's decision and order to cancel the PT and OT orders were not completed. During interview on 10/16/24, at 11:48 p.m., the director of nursing (DON) stated if a resident is admitted with therapy orders, the expectation was to evaluate and address with the provider. If the resident did not come in with orders, therapy should screen for orders. The facility policy Rehabilitation Services Orders dated 4/1/08, identified the facility provided physical, occupational or speech therapy to attain or maintain function and/or prevent decline with a physician-ordered treatment plan.