STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245138	A. BUILDING _____ B. WING _____	**04/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to implement a comprehensive infection control program to include the Centers for Medicaid and Medicare Services (CMS) COVID-19 recommendations to ensure immediate screening and surveillance of staff and visitors for potential COVID-19 symptoms before entering the facility and having contact with the residents. In addition, the facility further failed to implement CMS COVID-19 recommendations by continuing communal group activities. In addition, the facility failed to implement and follow appropriate measures to assess residents for symptoms of COVID-19 which included to monitor resident temperatures daily. These practices had the potential to affect all 38 residents who resided in the facility. Findings Included: On 4/8/20, at 11:08 a.m. three residents were observed sitting independently in the lobby area without masks, and were not within the recommended 6 feet apart for social distancing. On 4/8/20, at 11:35 a.m. the director of nursing (DON) and administrator were interviewed. The DON stated staff do self-screening for COVID-19 symptoms when they arrive to work. The DON stated staff enter through the side employee entrance, and walk through the nursing home to the nurses' station to complete their COVID-19 screening at the start of every shift. The administrator stated they were still utilizing the dining room for small group activities ensuring residents were 6 feet apart. On 4/8/20, at 11:38 a.m. employee COVID-19 screening documents were reviewed. The documented screenings indicated numerous employee COVID-19 screenings lacked temperatures, and the questionnaires were incomplete. On 4/8/20, at 12:19 p.m. the dietary manager (DM)-A stated COVID-19 all kitchen employees self-screened for COVID-19 symptoms upon arriving for work. DM-A stated the kitchen and dietary staff use the same employee entrance and walk through the facility, past the nurses' station, and to the kitchen to complete their COVID-19 self-screening. On 4/8/20, at 12:56 p.m. the DON and administrator were interviewed. The DON stated numerous employee COVID-19 self-screenings dated 3/20/20, through 4/8/20, were not completed. The administrator stated kitchen employees were allowed to walk through the facility to the kitchen to have individual COVID-19 self-screenings completed prior to working. On 4/8/20, at 1:10 p.m. dietary aid (DA)-A stated kitchen employees were instructed to complete COVID-19 self-screening when they came to work in the kitchen. On 4/8/20, at 12:19 p.m. nursing assistant (NA)-A was interviewed and stated she entered work through the side employee entrance. NA-A stated she would walk through the facility to the nurses' station to complete her COVID-19 self-screening at the start of every shift. NA-A further stated the NAs are responsible for taking daily temperatures on every resident, and documenting the results on a clip board located at the nurses' station. On 4/8/20, at 1:33 p.m. review of facility resident daily COVID-19 screenings revealed numerous daily COVID-19 screenings from dates 3/20/20, through 4/8/20, lacked documented temperatures for residents. On 4/8/20, at 2:04 p.m. the administrator stated the facility was to be completing daily temperatures of all residents to monitor for signs of COVID-19. The administrator verified with the facility was not properly monitoring and obtaining daily temperatures at they should have been. The administrator stated nursing was responsible for obtaining and reviewing resident temperatures daily. The administrator stated there was not proper oversight and implementation of surveillance for signs and symptoms of COVID-19, and or other infectious diseases for residents. On 4/8/20, at 2:16 p.m. activity director (AD)-A stated the facility was having small group communal activities in the facility main dining room. The AD-A stated staff were responsible for completing COVID-19 screening independently at the nurses' station upon the start of each shift. On 4/8/20, at 3:30 p.m. the administrator stated the facility's current practice of allowing an unscreened staff to walk through the building prior to being screened, could be creating a risk for spreading COVID-19. The facility COVID-19 (Coronavirus) Surveillance Plan-[MEDICAL CONDITION] (COVID-19) dated 3/12/20, directed implementation of staff screening tool to include taking daily temperatures and screening form, and continual tracking and trending of resident illness to include daily temperatures of residents. The facility policy Infection Prevention and Control - Addendum: COVID-19 Coronavirus, last revised 3/27/20, directed surveillance of all current residents will be completed by taking temperature and oxygen saturations daily, and group activates will cease on all units, and included dining and activities.

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