DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 20, 2023

Administrator
The Waterview Woods LLC
601 Grant Avenue
Eveleth, MN 55734

RE: CCN: 245277
Cycle Start Date: April 6, 2023

Dear Administrator:

On May 17, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 26, 2023

Administrator
The Waterview Woods Llc
601 Grant Avenue
Eveleth, MN 55734

RE: CCN: 245277
Cycle Start Date: April 6, 2023

Dear Administrator:

On April 6, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable 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 an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 July 6, 2023 (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 October 6, 2023 (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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
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
	245277	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/04/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW WOODS LLC	**601 GRANT AVENUE** **EVELETH, MN 55734**

(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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/04/2023. At the time of this survey, The Waterview Woods was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 05/04/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Waterview Woods LLC is a 2-story building with a full basement. The original building was constructed in 1961 with an 2nd floor addition constructed in 1965 to the 1961 building. In 1980 a 3-story addition with a basement was built all buildings are type II (111) construction. Therefore, the nursing home was inspected as one building. The building is fully fire sprinkler protected and has a complete fire alarm system with smoke	K 000		

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K 000	Continued From page 2 detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a capacity of 80 beds and had a census of 54 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by:	K 541		4/24/23

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K 541	Continued From page 3 Based on observation and staff interview, the facility failed to secure the laundry chute door per NFPA 101 (2012 edition), Life Safety Code section 19.5.4.1. This deficient finding could have a widespread impact on the residents within the facility. On 04/04/2023, between 11:45am and 2:45pm, it was revealed by observation that the laundry chute door located on the first floor Soiled Utility Room was missing the self-closer. An interview with the Assistant Maintenance Director, Administrator and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 541	K541 Rubbish Chutes, Incinerators, and Laundry Chu K541 CFR(s): NFPA 101 Immediate Corrective Action: Laundry chute closure ordered for replacement. Corrective Action as it applies to others: Laundry chute monitored to ensure closure when used. Laundry chute closure replaced on 4/24/2023. Date of Compliance: 4/24/23 Recurrence will be prevented by: Laundry chute to be audited to ensure proper closure. This will occur weekly x4 weeks then monthly times 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Maintenance Director or Designee	

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E 000	Initial Comments On 4/3/23 - 4/6/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/3/23-4/6/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiency issued: H52779927C (MN00091799) H52771000C (MN00092373) H52779871C (MN00092402) H52779945C (MN00092293) H52779850C (MN00091947) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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	F 000		

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

Electronically Signed | 05/04/2023

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

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F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure self-administration of medication assessment was completed or updated for 2 of 4 Residents (R5, R25) reviewed for self-administration of medication. R5's MDS review dated 2/13/23 indicated R5 was cognitively intact. R5's Diagnoses included: diverticulitis, rheumatoid arthritis, renal insufficiency, chronic pulmonary embolism, unspecified cirrhosis of liver, dependence on supplemental oxygen, major depressive disorder, and anxiety. R5's care plan indicated R5 could keep eye drops at bedside for self-administration. Although the care plan did not include leaving pills at bed side for self-administration. R5's medication administration record (MAR) did not identify R5 for self-administration of	F 554	F554 Self-Admin Meds-Clinically Approp Immediate Corrective Action: R5 and R25 Self-Administration assessment completed. MD signed off on self-administration order. Corrective Action as it applies to others: Self-Administration of Medications policy reviewed and remains current. All residents that are capable of self-administering medications reviewed to ensure a current self-administration assessment completed, self-administration order was obtained from provider, and that the care plan is up to date. All nurses/TMAs educated on process to only allow residents who have been identified on PCC dashboard as being ok to allow to self-administer medications without staff present.	5/9/23

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F 554	Continued From page 2 medications. Eye drops listed on MAR: artificial tears, one drop in right eye as needed for eye irritation. R5's self-administration of medication evaluation completed on 1/6/23 identified the resident as capable of self-administration of ophthalmic (eye) medication only: artificial tears at bedside. On 4/4/2023 in the a.m. R5 was sitting in bed. There was artificial tears and a paper cup containing multiple different pills sitting on R5's over the bed table. During a review of R5's MAR indicated R5's scheduled morning medications included: amlodipine 10 mg daily, arava 20 mg daily, vitamin C 500mg daily, bupropion HCL ER 300mg daily, cholecalciferol 200 mg daily, cranberry capsule 500 mg in the morning, ferrous sulfate 325mg in the morning, multivitamin daily, prednisone 10 mg in the morning, prenatal vitamin 27-1mg in the morning, sertraline HCL 100mg give 1.5 tabs in the morning, torsemide 20 in the morning, apixaban two times a day, fexofenadine 60 mg every 12 hours, labetalol 200 mg two times a day, losartan Potassium 50 mg two times a day, pantoprazole sodium 40 mg two times a day, hydralazine 100 mg three times a day, acetaminophen 1000 mg 3 times a day, oxycodone 10 mg four times a day. R25 R25's MDS dated 2/25/23 indicated R25 was cognitively intact. R25's Diagnosis: paraplegia incomplete, hypertension, delusional disorder. Heart disease, cataract, bi-polar, disorientation unspecified	F 554	Date of Compliance: 05/09/2023 Recurrence will be prevented by: 5 residents that self-administer medications will be audited to ensure that that have a current self-administration assessment, that resident is currently only self-administering the medications indicated, that provider order has been obtained, and that care plan is up to date. This will occur weekly x4 weeks then monthly times 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Director of Nursing or Designee	

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F 554	Continued From page 3 R25's care plan and medication administration record did not identify R25 as approved for self-administration of medication. R25's care plan listed alteration in cognition related to bi-polar, delusional disorder, confusion, paranoid behavior, and disorientation. R25 did not have a medication self-administration assessment documented in his chart. During an observation on 4/6/23 at 8:54 a.m., LPN-A placed the following medications into a medication cup. LPN-A took the medications into R25's room and informed R25 his morning medications were in the cup. LPN-A placed the medication cup on the bedside table and left the room before R25 took his medication. The medications in the cup included: Eliquis 5 mg 1 tab, fiber lax 625 mg, iron 1 tab, metoprolol 25 mg three tabs, omeprazole 20 mg every am do not crush 1 tab, vitamin D 25 mg two tabs. When interviewed, LPN-A stated staff could tell which residents can have medications left in the room because they would have a medication self-administration order. On 4/6/23 at 11:57 a.m., registered nurse manager (RN)-A stated nurses can leave some medications at bedside for some patients. RN-A said an assessment in completed to determine if a resident is safe to have medication left at the bedside for self-administration. If the resident is cognitively impaired, they would not qualify for self-administration and should be observed taking their medication. Staff are updated on who can self-administer medication. The care plan is updated, provider is consulted to sign-off, but	F 554		

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F 554	Continued From page 4 don't always get a formal order. If there is a change in resident condition a new self-medication assessment is completed. On 4/6/23 at 12:14 p.m., the director of nursing (DON) stated the nurse completes an self-administration assessment o determine if a resident is appropriate for medication self-administration. DON indicate the facility does require a provider order for self- administration, since the nurse can implement the assessment alone, but a lot of providers sign off when a resident is found to be appropriate to self-administer medications. The care plan is updated to reflect a resident's ability to self-administration. The Self-Administration of Medications policy dated May 2022 indicated residents who wish to self-administer medications may do so after a prescriber's order to self-administer is in place and an interdisciplinary team assessment has determined the resident can safely self-admin without putting self or others at risk. The policy included direction for assessments to be completed quarterly or with a significant change. The policy Medication Administration-General Guidelines dated May 2022 indicated residents can self-administer medications when specifically authorized by the attending physician and in accordance with Self-Administration of Medication policy. Policy also indicated the resident is always observed after a medication administration to ensure the dose was completely ingested.	F 554		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11)	F 577		5/9/23

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F 577	Continued From page 5 §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure three years of survey results/complaints were readily accessible and/or signage displaying their availability was visible for residents or visitors. This had the potential to affect all 53 residents, their families and any visitors who may have wished to review the information. Finding include:	F 577	F577 Right to Survey Results/Advocate Agency Info Immediate Corrective Action: Binder with three years of survey results/complaints were placed at the front entrance readily accessible to residents or visitors. Corrective Action as it applies to others: The Survey Results, Examination Policy	

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	245277	A. BUILDING _____ B. WING _____	C 04/06/2023

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F 577	Continued From page 6 During an observation on 4/5/23 at 3:38 p.m., a sign was posted on the wall next to a bulletin board near the front entrance. The sign indicated survey results and complaints for the past three years were available for review. During an interview on 4/5/23 at 3:39 p.m., the administrator stated she did not have the results in a binder and if requested by residents, families, or visitors the results would have to be obtained and printed for review. Survey Results, Examination of dated 4/2007, indicated copies of all survey reports would be on file in the administrative office. In addition, the policy indicated a copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisits reports, etc., along with state approved plans of correction of noted deficiencies, would be maintained in a 3-ring binder located in an area frequented by most residents, such as the main lobby or resident activity room.	F 577	was reviewed and remains current. Administrator and DON were educated on need for 3 years of survey results to be available in a frequently visited area of the building by all residents, staff, and visitors. Date of Compliance: 05/09/2023 Recurrence will be prevented by: Audits will occur weekly x 4 weeks and then monthly x 2 months to ensure that 3 years of survey results are available in the front entrance. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Administrator or Designee	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his	F 676		5/9/23

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F 676	Continued From page 7 or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assistance with routine grooming was provided for 1 of 1 female residents (R15) observed to have visible, long facial hair on her lip and chin. Findings include: R15's five-day assessment Minimum Data Set (MDS) dated 1/19/23, identified R3 was cognitively intact and demonstrated no rejection of care behaviors. Further, R3 required limited assistance of one staff member physical assist to	F 676	F676 Activities Daily Living (ADLs)/Mntn Abilities Immediate Corrective Action: R15 was offered the removal of facial hair. Corrective Action as it applies to others: The Dignity Policy and the ADL Policy were reviewed and remain current. All residents/families were interviewed to determine their preference for facial hair removal and care plans updated. Nurses, TMAs, and CNAs were educated	

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F 676	Continued From page 8 complete personal hygiene (including grooming). R15's care plan dated 4/20/22, identified R15 had an ADL self-care deficit due to weakness and listed a goal for R15 included assist of one for bath, assist of one for personal hygiene to set up and assist as needed. On 4/3/23 at 3:47 p.m., R15 was in her bed on the long-term care unit. R15 had visible white and brown colored facial hair present on her upper lip and chin. R15 stated she did not like the facial hair and wished the staff would help remove them. During subsequent observation on 4/5/23 at 8:42 a.m., R15 was again in her room laying in her bed. R15 continued to have visible white and gray colored facial hair present on her upper lip and chin. R15 stated the staff had given her a shower the evening before but had not offered to assist to remove facial hair since the week prior. During an interview on 4/5/23 at 9:37 a.m., nurse assistant (NA)-B stated personal hygiene and facial hair removal would be offered on bath day and daily if facial hair was noted on the face. NA-B verified R15's shower day was Sunday evening. She had been in R15's room earlier that day taking her breakfast tray in but had not looked at her face. R15 rolled past NA-B at this time and NA-B did confirm R15 had facial hair that "was longer than 3 days old". NA-B stated staff should have offered to remove facial hair several days ago. If the resident refused, then it would be reported to the nurse on duty. During an interview on 4/6/23 on 10:36 a.m., registered nurse (RN)-B stated personal hygiene	F 676	on need to remove facial hair per resident's preference as identified on their care plan. Date of Compliance: 05/09/2023 Recurrence will be prevented by: Audits of 5 residents to ensure removal of facial hair was offered per preference as identified on their care paln during daily ADLs. This will occur weekly x4 weeks then monthly times 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Director of Nursing or Designee	

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F 676	Continued From page 9 and facial hair removal would be offered daily and with showers. If resident refused the NA would report to nurse so it could be documented. Refusals would then be documented in the progress notes. RN-B reviewed R15's progress notes and confirmed R15 received a partial bed bath on 4/2/23. There was no documented refusal for personal hygiene or facial hair removal in the progress notes since the partial bed bath on 4/2/23. During and interview on 4/6/23, on 1:12 p.m. the director of nursing (DON) stated there was an expectation staff offer facial hair removal daily and to document refusal each time refused. The DON stated documentation should specifically include refusal of facial hair grooming if it was refused. Facility policy Dignity dated 2021, indicated residents would be groomed as they wished. A facility personal hygiene policy was requested but not provided.	F 676		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure an appropriate assessment for dialysis residents were completed	F 698	F698 Dialysis Immediate Corrective Action:	5/9/23

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F 698	Continued From page 10 for 1 of 1 resident (R) 8 reviewed for Dialysis. Findings include: R8's diagnosis included: End stage renal disease, dependance on renal dialysis, chronic diastolic congestive heart failure, acute pulmonary edema, and type II diabetes. R8's Minimum data set (MDS) assessment dated 2/16/23 identified R8 as cognitively intact and a recipient of dialysis. R8's care plan identified R8 was at risk for complications related to dialysis with goals listed R8 will attend dialysis per schedule and resident will have no uncontrolled bleeding from the fistula, shunt, or central line. Interventions included: R8 will be sent to ER for uncontrolled bleeding from site, fluid restriction, notify provider of excessive/uncontrolled bleeding, elevated temp. Monitor bruit left arm every shift (whooshing sound). R8's orders included to assess site including bruit and thrill pre and post dialysis and every shift. On 4/6/23 at 1:10 p.m., LPN-A sanitized hands, applied a glove, located R8 in the dining area and asked to assess R8's dialysis site. R8 agreed. LPN-A lifted sleeve and placed fingers on access site. LPN-A did not listen to site with a stethoscope for bruit. LPN-A removed glove and sanitized hands. On 4/6/23, R8 stated after return from dialysis, the staff offer me a snack and sometimes staff take my vital signs. But they do not check my	F 698	R8's dialysis site was assessed for bruit and thrill. Corrective Action as it applies to others: Hemodialysis policy reviewed and remains current. All current residents that have dialysis will be reviewed to ensure that their dialysis site is being monitored and bruit and thrill pre and post dialysis are completed every shift. All nurses will be educated on monitoring a dialysis site and checking bruit and thrill per TAR. Competency Assessment Hemodialysis Access Care was completed with all current nurses and new hires going forward. Date of Compliance: 05/09/2023 Recurrence will be prevented by: Audit of all residents on dialysis will be completed to ensure assessment of dialysis site, bruit and thrill completed per and post dialysis and every shift. This will occur weekly x4 weeks then monthly times 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Director of Nursing or Designee	

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F 698	Continued From page 11 dressing or listen over my site. The dialysis staff take care my site before R8 leaves. R8 removes the dressing them self on days R8 does not have dialysis. R8 stated they do not recall anyone listening to the access site, and said, " I think I would recall that." On 4/6/23 at 9:07 a.m., LPN-A stated R8 receives dialysis Monday, Wednesday, and Fridays. On dialysis days medications are given before R8 leaves. LPN-A indicated when R8 returns to the facility, staff take R8's vital signs and the site is assessed and checked for bruit and thrill. R8 will sometimes refuse to get vitals done. LPN-A stated the facility did not provide any formal dialysis care or site assessment education; new nurses learn this from other nurses during orientation. On 4/6/23, at 1:14 p.m. registered nurse manager (RN)-A stated R8 does not have cognitive or memory issues. For dialysis care, nurses are to assess access site and obtain vitals before R8 leaves and when R8 returns from dialysis. The access site also gets assessed each shift. If there is bleeding, staff would apply pressure on the site and notify provider if needed. RN-A stated the staff has had to notify provider in the past. Assessing bruit and thrill is something staff complete each shift. RN-A initially stated staff can either assess by feel or listen, but they didn't have to do both. RN-A then reviewed the order and stated staff should be doing both with each assessment. RN-A reviewed documentation in chart and indicated that nurses were signing off that they were assessing bruit and thrill each shift. Nurse Practitioner (NP) was present during	F 698		

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F 698	Continued From page 12 interview and confirmed the nurses should be listening for bruit and feeling for thrill each time they assessed R8's access site. On 4/6/23, at 1:29 p.m. the director of nursing (DON) stated R8 seemed cognitively intact each time she had spoken with him. The DON stated she would expect nurses to assess site for bleeding and check bruit and thrill with each assessment. The DON stated to perform the assessment, nurses need to palpate site for thrill and listen at the site for bruit with a stethoscope. The DON stated the facility has not done any formal dialysis patient care education for the nurses. New nurses get training from other nurses that do medication pass. Hemodialysis policy dated 11/22/19 instructed staff on how to perform access assessment. Assessment components included patency: feel the access for thrill, listen with a stethoscope for bruit. The documentation portion of the policy read documentation should include, but is not limited to, pre and post dialysis assessment/observation, daily check of the access site (fistula, graft, or external catheter), and evaluation for signs and symptoms of infection. Documentation of nurse competency for all nurses that assess dialysis access was requested. The facility provided a blank five-page document entitled Competency Assessment Hemodialysis Access Care.	F 698		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under	F 727		5/9/23

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F 727	Continued From page 13 paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a registered nurse (RN) was scheduled for a minimum of eight hours a day. This had the potential to affect all 53 residents who resided at the facility. Findings include: Review of the facility Staffing Schedules dated 1/2/23, through 4/6/23, revealed there was no RN coverage for: 6 days in January 5 days in February 8 days in March and on April 1 and 2nd. During an interview on 4/6/23, at 10:09 a.m. nursing assistant (NA)-A stated she had trouble scheduling a registered nurse (RN) on the weekends as there was only one RN who was not a manager. During an interview on 4/6/23, at 12:49 p.m. licensed practical nurse (LPN)-A verified she worked weekends and there was not always an	F 727	F727 RN Hours Immediate Corrective Action: Request for RN Coverage Waiver was submitted. Corrective Action as it applies to others: Educate all nursing staff of the RN on call 24/7 and provide contact information as needed. Date of Compliance: Date of compliance will be determined by recruitment and on-boarding of additional RN leadership staff. Recurrence will be prevented by: Retention efforts of current RN staff. Retention efforts will be shared with the facility QAPI committee for input. Corrections will be monitored by: Administrator/Designee	

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F 727	Continued From page 14 RN working on weekends. LPN-A stated on shifts when there was not an RN working she would look at the on-call schedule and call the clinical manager or director of nursing (DON) who was scheduled, if they did not answer she would just "keep going down the line" until she reached one of them. During an interview on 4/6/23, at 1:01 p.m. the director of nursing (DON) verified there was not RN coverage on the weekends. The DON stated there was always an RN on call. The DON stated it was important to have RN coverage for assessments and overseeing resident care. The DON verified RN coverage had been a concern over the past two years. During an interview on 4/6/23, at 1:05 p.m. the administrator verified there had not been RN coverage on the weekends and the RN positions had been posted did not have applicants and so were filled by LPN's. During an interview on 4/6/23, at 1:34 p.m. LPN-C verified she worked weekends and on some weekends there was not an RN working. A facility policy on RN coverage was requested but not provided. On 4/6/23, at 1:55 p.m. the administrator verified via email, "We are to follow the regulation for the RN coverage, but do not have a policy".	F 727		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		5/9/23

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F 759	Continued From page 15 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure they were free of a medication administration error rate of 5 percent (%) or greater. The facility had an error rate 12.5% based on 4 errors out of 32 opportunities for error involving 2 out of 6 residents (R15, R23) who were observed for medication pass. Findings include: On 4/6/23, 8:54 a.m. during an observed medication pass for R15, LPN-A placed the following medications into a medication cup: Eliquis 5 mg 1 tab, calcium polycarbophil 625 mg 1 tab, iron 1 tab, metoprolol 25 mg three tabs 3, omeprazole 20 mg every am do not crush 1 tab, and vitamin D 25 mg two tabs. Order review indicated that R15's morning calcium polycarbophil was ordered as: give 1250 mg by mouth two times a day. LPN-A confirmed R15 should get two tablets of calcium polycarbophil and added an additional tab to R15's medication cup to equal the correct 1250 mg dose. On 4/6/23, at 9:07 a.m. during a observed medication pass LPN-A placed the following medications in a medication cup for R23: cephalexin 500mg, benztropine bid 1 tab, gemfibrozil 600 mg 30 minutes before meal 1tab, polyglycol - 1 dose 8 oz water, vitamin D 25 mcg 5 tabs, clozaril 100 mg 3 tabs plus clozaril 25 mg 1 tab, stool softener colace 100 mg 1 tab, fluoxetine one cap daily 1 cap, lorazepam 1 mg two times a day 1 tab (recorded dose in control	F 759	F759 Free of Medication Error Rts 5 Prcnt or More Immediate Corrective Action: The LPN was educated on need to follow MAR instructions for medication administration and the process of what to do if a medication is not available for administration. Corrective Action as it applies to others: Medication Administration-General Guidelines policy was reviewed and remains current. All residents that have specific medication administration times/instructions reviewed and adjusted to ensure residents receive medications at the proper time. All residents were reviewed to ensure they have all ordered medications available for administration. All nurses will be educated on following medication administration orders, reordering medications timely, and the need to call MD if a medication is not available for orders to hold or provide alternative when medication is available from pharmacy. Date of Compliance: 05/09/2023 Recurrence will be prevented by: 5 residents medication administration will be audited to ensure proper dose and	

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F 759	Continued From page 16 book), omeprazole 40 mg daily before morning meal 1 tab, Vitamin C 500 mg 1 tab and tums 1 tab. LPN-A double checked med cart and stated R23 was out of Senna Plus which was ordered to give two times a day. LPN-A ordered senna plus, and then proceeded to R23's room. LPN-A observed R23 take his pills and told R23 the senna was on order. R23 stated "I ate breakfast around 8:00 a.m." After medication pass LPN-A confirmed R23 should get omeprazole and gemfibrozil before meals as ordered; everyone does their best to give medications before meals when ordered that way, but sometimes it doesn't happen. LPN-A confirmed R23 would miss his morning dose of senna plus but the pharmacy should deliver medications by 8 p.m. so R23 should be able to get scheduled evening dose. On 4/6/23, at 11:57 a.m. registered nurse manger (RN)-A stated mediations like omeprazole and cholesterol medications should be given before meals when ordered that way. RN-A stated the facility should not run out of a resident's medications. On 4/6/23, at 12:14 p.m. the director of nursing (DON) stated all nurses are expected to follow medication administration orders. When medications are ordered with specific administration times like before meals, the expectation is residents get those medications before meals. The Self-Administration of Medications policy dated May 2022 indicated residents who wish to self-administer medications may do so after a prescriber's order to self-administer is in place and an interdisciplinary team assessment has	F 759	time related to the physician order and that if a medication is not available that they called MD for direction to hold or provide alternative until med is available. This will occur weekly x4 weeks then monthly times 2 months. The results of the audits will be shared with the facility QAPI committee for input in the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Director of Nursing or Designee	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW WOODS LLC	601 GRANT AVENUE EVELETH, MN 55734

(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 759	Continued From page 17 determined the resident can safely self-admin without putting self or others at risk. The policy included direction for assessments to be completed quarterly or with a significant change. The policy Medication Administration-General Guidelines dated May 2022 instructed: the facility will have a sufficient medication distribution system in place to ensure safe administration of medications without unnecessary interruptions and medications will be administered in accordance with the written orders of the prescriber.	F 759		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		5/9/23

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F 880	Continued From page 18 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 19 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to establish a water management plan to prevent waterborne pathogens including Legionella. This had the potential to affect all 53 residents who resided in the facility. Findings include: According to the Centers for Disease Control and Prevention there are seven key elements of a Legionella water management program. They are as listed below: -Establish a water management program team -Describe the building water systems using text and flow diagrams -Identify areas where Legionella could grow and spread -Decide where control measures should be applied and how to monitor them -Establish ways to intervene when control limits are not met -Make sure the program is running as designed (verification) and is effective (validation) -Document and communicate all the activities During an interview on 4/6/23, at 9:50 a.m. maintenance staff (MS)-A stated he would check the water temperature every morning coming from the boiler, he stated the assisted living was not occupied so he would pick two rooms daily and run the sink and showers for several minutes and flush the toilets. MS-A stated he was not aware of any diagrams showing the building's	F 880	F880 Infection Prevention & Control Immediate Corrective Action: Facility is setting up a water management team and developing a facility specific water management program to reduce risk of Legionnaire's disease. Corrective Action as it applies to others: The Legionella Water Management Program Policy was reviewed and updated. The facility is setting up a water management team and developing a facility specific water management program to reduce risk of Legionnaire's disease. Environmental Staff and Administrator were educated on needing to set up a facility specific water management program and ensuring that it is kept up to date. Date of Compliance: 05/09/2023 Recurrence will be prevented by: Audits will be completed to ensure that there is a system in place to identify risk areas for Legionella and that facility plan is being reviewed annually and with any change at facility. This will occur weekly x4 weeks then monthly times 2 months. The results of the audits will be shared	

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F 880	Continued From page 20 water systems with text and flow diagrams, nor was he aware of any water management plan/program to prevent Legionella and other waterborne pathogens. During an interview on 4/6/23, at 1:38 p.m. the administrator verified the Legionella Water Management Program should be followed to prevent Legionella and other waterborne pathogens. The Legionella Water Management Program dated 7/2017, indicated the purpose of the water management program was to identify areas in the water system where Legionella bacteria could grow and spread and to reduce the risk of Legionnaire's disease. The water management program included the following: -an interdisciplinary water management team -a detailed description and diagram of the water system in the facility -the identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria -the identification of situations that could lead to Legionella growth -specific measure used to control the introduction and/or spread of Legionella -the control limits or parameters that are acceptable and that are monitored -a diagram of control limits and the effectiveness of control measures -a plan for when the control measures were not met -documentation of the program The plan also indicated the water management would be reviewed at a minimum of once a year.	F 880	with the facility QAPI committee for input in the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Environmental Services/Administrator/Designee	

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F 880	Continued From page 21 spread.	F 880		