DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 16, 2020

Administrator
The Waterview Shores Llc
402 - 13th Avenue
Two Harbors, MN 55616

RE: CCN: 245471
Cycle Start Date: May 11, 2020

Dear Administrator:

On May 11, 2020, the Minnesota Department of Health, 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,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245471	A. BUILDING _____ B. WING _____	R 05/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW SHORES LLC	**402 - 13TH AVENUE TWO HARBORS, MN 55616**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	{E 000}		
{F 000}	INITIAL COMMENTS A revisit was conducted 5/11/20, to determine compliance with Federal deficiencies issued during a COVID focused infection control survey exited on 4/10/20. The facility's deficiencies were all corrected. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

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

Electronically Signed | 05/18/2020

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

Electronically delivered
April 24, 2020

Administrator
The Waterview Shores LLC
402 - 13th Avenue
Two Harbors, MN 55616

SUBJECT: SURVEY RESULTS
CCN: 245471
Cycle Start Date: Cycle Start Date: April 10, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On April 10, 2020, a survey was completed at your facility by the Minnesota Department of Health completed a COVID-19 Focused Survey at The Waterview Shores Llc to determine if your facility was in compliance with Federal requirements related to the implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable plan of correction (POC) for the enclosed deficiencies that were cited during the April 10, 2020 survey. The Waterview Shores Llc may choose to delay submission of a POC until after the survey and enforcement suspensions have been lifted. The provider will have ten days

from the date the suspensions are lifted to submit a POC. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC 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; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to:

Teresa Ament, Unit Supervisor
Email: teresa.ament@state.mn.us
Fax: (218) 723-2359

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 10, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Teresa Ament, Unit Supervisor
Email: teresa.ament@state.mn.us
Fax: (218) 723-2359

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the

Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

The Waterview Shores Llc may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW SHORES LLC	402 - 13TH AVENUE TWO HARBORS, MN 55616

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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 4/8/20, through 4/10/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facilty acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted 4/8/20, through 4/10/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined not to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		5/2/20

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

Electronically Signed | 04/29/2020

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F 880	Continued From page 1	F 880		

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;

§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

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F 880	Continued From page 2 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. §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 observation, interview, and document review, the facility failed to implement a comprehensive infection control program with current Centers for Medicaid and Medicare Services (CMS) and Centers for Disease Control (CDC) guidelines for COVID-19 to ensure immediate screening and surveillance of staff and visitors for potential COVID-19 symptoms prior to entering the facility and having contact with the residents. In addition, the facility failed to implement consistent daily monitoring of 8 of 9 residents (R1, R2, R3, R4, R5, R6, R7, and R9) for symptoms of COVID-19. In addition, the	F 880	Immediate corrective action: All staff/visitors now entering building come in through one entrance and are screened at the door before coming into the facility. Residents (R1, R2, R3, R4, R5, R6, R7, and R9) will be assessed to ensure that they are fever free and do not have any other symptoms of infection. Residents' (R3, R4, R5, R6, R7, and R8) eating areas will be reassessed to ensure that they will be placed no less than 6 feet from any other residents.	

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F 880	Continued From page 3 facility failed to ensure residents who required assistance with dining maintained a distance of at least 6 feet of separation from other residents during socialization and dining to prevent exposure and spread of COVID-19 for 6 of 11 residents (R3, R4, R5, R6, R7, and R8) observed in the dining room prior to and during meal service. These practices had the potential to affect all 38 residents who resided in the facility and staff. Findings include: On 4/8/20, at 11:50 a.m. upon entrance into the facility, a clipboard was on a table with a questionaire regarding symptoms of COVID-19, and recent risk of exposure to COVID-19 to be filled out upon entrance. The director of nursing (DON) directed surveyor to fill it out, and then to go to the West nurse's station to have a temperature taken. The DON then brought the thermometer to the entrance to take temperature to screen for symptoms of COVID-19. The DON stated they usually had visitors and staff report to the West nurses station to have their temperature taken and questionnaire reviewed. On 4/8/20, at 1:27 p.m. a hospice staff entered the building, filled out a questionnaire, came in through the door, was stopped at the desk and told to bring the form down to the West nurses station. Hospice staff walked down the hall in the facility to the west nurse's station, and had her temperature taken by licensed practical nurse (LPN)-A, prior to beginning resident visit. On 4/8/20, at 1:30 p.m. LPN-A was interviewed and stated visitors, such as hospice and therapy, come in the front door, and check in on the West	F 880	Action as it applies to others: The Policy for COVID-19 remains current. All staff/visitors are entering building through one entrance and are screened at the door including screening questions and taking temperatures. All staff will be educated on the need to enter building through one entrance and the need to have another person complete the screening process with them including asking the questions and taking the temperature and sign off on the screening form. All residents were reviewed to ensure that they have daily monitoring of temperatures, O2 sats, and respiratory status. If they have any symptoms, then monitoring will be increased to be twice a day or as needed per individualized needs. All nurses and TMAs will be educated on the importance of needing to complete the identified monitoring. All residents will be assessed to ensure that if they are at least 6 feet apart from other residents when eating. All staff will be educated on need to ensure that residents are at least 6 feet apart from others when eating. Recurrence will be prevented by: Audits of staff/visitor screening process will be completed 5x/week x 1 week, then 3x/week for 3 weeks, then 1x/week for 2	

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F 880	Continued From page 4 nurses station. LPN-A stated she would review their questionnaires, and take their temperature. LPN-A stated if the temperature was greater than 100 degrees Fahrenheit (F) or if they answered "yes" to a screening question on the questionnaire, she would call the registered nurse or DON and follow directions, and that person would be sent home. LPN-A stated staff entered the facility opposite the West nurses station, walked past dietary department, and got a mask and came to the nurse's station to fill out a questionnaire and have their temperature taken. LPN-A stated everyone entering the building, even after being at facility, leaving to another setting, and returning would have their temperature taken upon re-entering the facility. A review of staff and visitor screenings indicated there were 33 separate occurrences of staff and visitor screenings without documentation of temperatures between 4/1/20, and 4/8/20. On 4/8/20, at 2:55 p.m. the DON verified staff and visitor screenings prior to beginning work or visiting a resident should include a temperature, and stated it was not good if temperatures were not taken prior to beginning work. The DON stated staff would be sent home if they had a temperature of greater than 100 degrees F or if the displayed symptoms of COVID-19. The DON verified staff and visitors had to walk into the building and down the hall to a resident area to be screened. R1's Weights and Vitals Summary dated between 3/17/20, and 4/8/20, indicated R1's temperature was not monitored on five days, including 4/5/20, and oxygen saturation levels were not monitored on 17 days.	F 880	weeks, then monthly x 2 months and the results shared with the QAPI on the need to increase, decrease, or discontinue the audits. Audits of resident temperatures, O2 sats, and respiratory status will be completed on all residents 5x/week x 1 week, then 3x/week for 3 weeks, then 1x/week for 2 weeks, then monthly x 2 months and the results shared with the QAPI on the need to increase, decrease, or discontinue the audits. Audits will be completed on 6 residents in different dining areas to ensure that they are no less than 6 feet apart during meals 5x/week x 1 week, then 3x/week for 3 weeks, then 1x/week for 2 weeks, then monthly x 2 months and the results shared with the QAPI on the need to increase, decrease, or discontinue the audits. The correction will be monitored by: DON/ADON/Designee	

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F 880	Continued From page 5	F 880		

R1's progress notes dated 4/6/20, indicated R1's physician was notified of R1's complaints of a sore throat and cough, and temperature that was elevated two degrees above R1's baseline temperature. R1's physician ordered lab tests to assist in identifying the cause of R1's symptoms, including influenza and COVID-19.

R2's Weights and Vitals Summary dated between 3/17/20 and 4/8/20, indicated R2's temperature was not monitored on nine days, and oxygen saturation levels were not monitored on 18 days.

R3's Weights and Vitals Summary dated between 3/17/20, and 4/8/20, indicated R3's temperature was not monitored on four days, and oxygen saturation levels were not monitored on 12 days.

R4's Weights and Vitals Summary dated between 3/17/20, and 4/8/20, indicated R3's temperature was not monitored on seven days, and oxygen saturation levels were not monitored on 18 days.

R5's Weights and Vitals Summary dated between 3/17/20, and 4/8/20, indicated R5's temperature was not monitored on seven days, and oxygen saturation levels were not monitored on 18 days.

R6's Weights and Vitals Summary dated between 3/17/20, and 4/8/20, indicated R6's temperature was not monitored on eight days, and oxygen saturation levels were not monitored on 19 days.

R7's Weights and Vitals Summary dated between 3/17/20, and 4/8/20, indicated R7's temperature was not monitored on eight days, and oxygen saturation levels were not monitored on 18 days.

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F 880	Continued From page 6 R9's Weights and vitals Summary dated between 3/17/20, and 4/8/20, indicated R9's temperature was not monitored on 7 days, and oxygen saturation levels were not monitored on 19 days. On 4/8/20, at 4:25 p.m. DON verified residents should be monitored for symptoms of COVID-19 at least daily with temperatures, oxygen saturation levels, and respiratory symptoms. The facility policy Coronavirus (COVID-19) revised 4/2/20, directed staff be screened for fever and respiratory symptoms prior to beginning of the shift, and be actively screened with temperature and documentation of symptoms, visitors to be screened and temperature taken prior to further entrance to the facility, and each resident's temperature, oxygen saturations, and respiratory status would be monitored and documented at least twice daily. On 4/8/20, at 12:06 p.m. four residents were observed seated in dining room B either together or at tables that were not six feet apart. A staff member was going around the dining room offering residents who were seated at the dining room tables wipes to clean their hands prior to the noon meal service. The trained medication aide (TMA)-A was interviewed and stated all of the residents in dining room B had to be there because they required assistance or supervision with eating. At 12:18 p.m. the East dining room had five	F 880		

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F 880	Continued From page 7	F 880		

residents in the dining room. Two were seated at a dining room table across from each other. Staff moved one of these residents to the nurse's station where an overbed table had been set up to accommodate his lunch meal, leaving the other four residents at individual tables, approximately six feet apart.

At 1:51 p.m. TMA-A stated the facility had provided training on COVID-19, stating the training included keeping residents six feet apart.

On 4/9/20, at 3:05 p.m. an interview was conducted with the DON. The DON stated she did not know the measurements of the dining room tables, and verified some residents were seated closer than six feet from one another.

The facility policy Coronavirus (COVID-19) revision date 4/2/20, directed group activities and communal dining should be canceled until further guidance is provided. Residents requiring assistance or supervision with eating may continue to be served meals in the dining room or common area, as long as they are without symptoms of a respiratory illness. The facility will make every effort to maintain social distancing of at least six feet between residents.