DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WWVA

Facility ID: 00583

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245277**

2.STATE VENDOR OR MEDICAID NO.
(L2) **175197200**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE WATERVIEW WOODS LLC**
(L4) **601 GRANT AVENUE**
(L5) **EVELETH, MN** (L6) **55734**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/01/2019**

6. DATE OF SURVEY **03/16/2022** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Susan Frericks, Unit Supervisor 03/23/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 03/23//2022 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/10/2022
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 23, 2022

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

RE: CCN: 245277
Cycle Start Date: January 21, 2022

Dear Administrator:

On February 4, 2022, we notified you a remedy was imposed. On March 16, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 3, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 19, 2022 be discontinued as of March 3, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of February 4, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 21, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Signature block here

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

March 23, 2022

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

RE: Project Number

Dear Administrator:

On March 17, 2022, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $300.00 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on March 16, 2022 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $300.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $46.40, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $346.040 within 15 days of the receipt of this notice. That check should be forwarded to:

Department of Health
Health Regulation Division,
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Sincerely,

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

cc: Shellae Dietrich, Program Assurance Superviosr
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WWVA

Facility ID: 00583

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5. Validation 6. Complaint
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8. Full Survey After Complaint

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And/Or Approved Waivers Of The Following Requirements:
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17. SURVEYOR SIGNATURE — Date :
Jamie Boser, HFE - NE II — 03/10/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Enforcement Specialist — 03/22/2022 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

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___ 2. Facility is not Eligible
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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04/01/1985
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25. LTC EXTENSION DATE:
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27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

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02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/10/2022
(L33)

DETERMINATION APPROVAL

Electronically delivered
March 10, 2022

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

RE: CCN: 245277
Cycle Start Date: January 21, 2022

Dear Administrator:

On February 4, 2022, we informed you of imposed enforcement remedies.

On March 2, 2022, the Minnesota Department(s) of Health and Public Safety completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency(ies) not corrected is/are as follows:

F0880 -- S/S: D -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Prevention & Control

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 19, 2022, will remain in effect.

- Directed plan of correction, Federal regulations at 42 CFR § 488.424 Please see electronically attached documents for the DPOC.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 19, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 19, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial

compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of February 4, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 21, 2022.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an"E" tag), i.e., the plan of correction should be directed to:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 21, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ 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 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, Enforcement Specialist
Minnesota Department of Health
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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically delivered

March 17, 2022

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

Re: CCN: 245277
Cycle Start Date: January 21, 2022

Dear Administrator:

On March 2, 2022, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 21, 2022 with orders received by you electronically on February 4, 2022.

State licensing orders issued pursuant to the last survey completed on January 21, 2022, found not corrected at the time of this March 2, 2022 revisit and subject to penalty assessment are as follows:

21390 -- S/S: -- MN Rule 4658.0800 Subp. 4 A-I -- Infection Control $300.00

The details of the violations noted at the time of this revisit completed on March 2, 2022 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, § 144A.10, you will be assessed an amount of $300.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900 Mobile: (218) 368-4467
Email: susan.frericks@state.mn.us

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to:

Shellae Dietrich, Program Assurance Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Sincerely,

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

Enclosure

cc: Licensing and Certification File
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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(L9) **06/01/2019**

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12/31

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To (b) :

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE — Date :
Colleen Johnson HFE - NE II — 02/16/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Enforcement Specialist — 03/10/2022 (L20)

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B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
February 4, 2022

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

RE: CCN: 245277
Cycle Start Date: January 21, 2022

Dear Administrator:

On January 21, 2022, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On January 20, 2022, the situation of immediate jeopardy to potential health and safety cited at F 678 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 19, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 19, 2022 (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 19, 2022, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 21, 2022. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information,

you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Waterview Woods Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 21, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/ or "E" tag), i.e., the plan of correction should be directed to:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 21, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this

letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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, Enforcement Specialist
Minnesota Department of Health
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
	245277	A. BUILDING _____ B. WING _____	C 01/21/2022

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
E 000	Initial Comments On 1/18/22, through 1/21/22, 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 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.	E 000		
F 000	INITIAL COMMENTS On 1/18/22, through 1/21/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F678 when the facility failed to ensure F21's advance directive/code status was consistent throughout their records to ensure the code status reflected resident current resuscitation preferences and physician orders. The IJ began on 1/19/22, and the immediacy was removed on 1/20/22. The above findings constituted substandard quality of care, and an extended survey was conducted from 1/26/22 to 1/27/22. The following complaints were found to be SUBSTANTIATED: H5277089C (MN78781), H5277090C (MN78825), H5277091C (MN79366)	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/10/2022

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 however NO deficiencies were cited due to actions implemented by the facility prior to survey: 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 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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		2/14/22

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F 580	Continued From page 2 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure timely notification to the physician of increased oxygen needs for 1 of 3 residents (R18) reviewed for respiratory care. Findings include: R18's Admission Record printed on 1/21/22, indicated R18 had diagnoses which included	F 580	F580 Notify of Changes (Injury/Decline/Room, etc) Immediate Corrective Action: Resident 18's MD was notified of increased oxygen needs and new oxygen order were obtained. Corrective Action as it applies to others: Oxygen General Guidelines were	

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F 580	Continued From page 3 heart failure (a chronic condition in which the heart does not pump blood as well as it should), chronic obstructive pulmonary disease (COPD [a group of lung diseases that block airflow and make it difficult to breathe]), moderate persistent asthma, shortness of breath, and edema. R18's admission Minimum Data Set (MDS) dated 11/18/21, indicated R18 was cognitively intact, required extensive assistance with activities of daily living (ADLs), and required oxygen. R18's care plan initiated on 11/12/21, indicated R18 was at risk for an alteration in oxygen/gas exchange. Interventions included in R18's care plan were to monitor oxygen saturations as ordered and as needed, administer oxygen as ordered, and keep medical doctor (MD) informed of changes. R18's physician orders dated 11/12/21, directed staff to use oxygen at one to two liter per minute as needed for dyspnea (shortness of breath) per nasal cannula, in addition staff were to notify the Medical Doctor (MD) if R18 needed an increase in oxygen above one to two liters longer than 24 hours. R18's physician orders dated 11/12/21, directed staff to check R18's oxygen saturations every shift related to COPD. R18's treatment record indicated R18's oxygen saturations were checked every shift on January 1, 2, 3, 4, 6, 7, 8, 9, 10, 12, 13, 14, 16, 17, 18, and 19, 2022, with no indication of how many liters of oxygen she was on. On January 5, 11, and 15, 2022, R18's oxygen saturations were checked on two of the three shifts, again with no indication of amount of oxygen used.	F 580	reviewed and remain current. All residents using oxygen will be reviewed to ensure that they have current oxygen orders and that order requires staff to put in amount of oxygen is being used for that shift. All nursing staff will be educated on need to follow current oxygen orders and to notify MD if indicated. Date of Compliance: 02/14/2022 Recurrence will be prevented by: 5 residents that use oxygen will be audited to ensure that they have current oxygen orders, that resident is receiving the ordered amount, and that MD was notified if there was an increased need in flow. 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 580	Continued From page 4	F 580		

R18's progress note dated 1/15/22, at 1:51 a.m. indicated R18 was confused, agitated, and restless. The note indicated she was repeatedly removing her oxygen. The note indicated once R18 left her oxygen on (no indication of how many liters of oxygen were in use) her oxygen saturations were up to 90%. No indication the MD was notified.

R18's progress note dated 1/12/22, at 1:33 p.m. indicated R18's oxygen saturations were 76% on three liters of oxygen. Oxygen was increased to four liters of oxygen and R18 was encouraged to take deep breaths, the note indicated R18's oxygen saturations were 95%. Oxygen was decreased to three liters and oxygen saturations remained in the 90's. Nothing in the progress note indicated the MD had been notified.

R18's progress note dated 1/12/22, at 1:20 p.m. indicated R18 was having dyspnea and complaining of abdominal pain, her oxygen was at one liter and her oxygen saturation was 75%. R18's oxygen was increased to three liters, she was given pain medication and maintained oxygen saturations around 90%. The note indicated the clinical manager was notified but there was no indication the MD was notified.

On 1/20/22, at 9:14 a.m. R18 was observed wearing nasal cannula, her oxygen was set at 3.5 liters per minute.

On 1/20/22, at 3:52 p.m. licensed practical nurse (LPN)-C verified R18's oxygen was set at 3.5 liters per minute. LPN-C stated she had not received any report from the previous shift about an increase in oxygen for R18. LPN-C was not sure when the increase in oxygen had taken

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F 580	Continued From page 5 place or if it had been reported to R18's MD. LPN-C stated she was going to talk to her clinical manager to see what to do. R18's progress note dated 1/20/22, at 4:23 p.m indicated R18's provider was notified about her oxygen saturations and her increased need for oxygen. R18's physician orders were updated on 1/20/22, to increase her oxygen to one to four liters as needed to keep her oxygen saturations greater than 90%. On 1/21/22, at 9:54 a.m. physician (P)-C verified she was first notified of R18's increased oxygen needs on 1/20/22. P-C verified she would have expected staff to notify her of R18's increased oxygen needs as per the order of 11/12/21. On 1/21/22, at 12:15 p.m. the director of nursing (DON) verified she would expect staff to contact the physician of a resident's increased need for oxygen as ordered. The DON verified the shift documentation did not indicate how many liters of oxygen were in use. The facility policy titled Oxygen General Guidelines dated 9/2011, indicated the resident's physician would submit orders for oxygen. The policy directed staff to record the use of oxygen in the medical record to indicate flow rate, mode of administration, frequency, duration of use, vital signs, lung sounds and skin conditions as indicated by the resident condition. In addition the resident's response to oxygen.	F 580		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		2/14/22

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(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 625	Continued From page 6 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure written notification of the bed hold was provided to 1 of 3 residents (R16) reviewed for hospitalization. Findings include: R16's Admission Record printed on 1/22/21,	F 625	F625 Notice of Bed Hold Policy Before/ Upon Trnsfr Immediate Corrective Action: All current residents that are out of building were reviewed to ensure that they have a bed hold form completed.	

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	245277	A. BUILDING _____ B. WING _____	C 01/21/2022

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F 625	Continued From page 7 indicated R18 was admitted to the hospital on 1/11/22, and again on 1/14/22. R16's medical record lacked documentation of a written bed hold notice provided to the resident or the resident's representative. On 1/21/22, at 10:03 a.m. social services (SS)-A stated nursing would fill out the bed hold and get it signed by the resident or resident representative. SS-A reviewed R16's electronic medical record and was unable to find any bed holds. On 1/21/22, at 10:11 a.m. licensed practical nurse (LPN)-B provided a binder that staff nurses woud use when they send a resident to the hospital. The binder contained the policy Transfer or Discharge, Emergency policy, dated 12/2016, and bed-hold notice forms to be filled out upon transfer to the hospital. LPN-B stated she was aware of the need to fill out a bed-hold form. On 1/21/22, at 12:21 p.m. the director of nursing (DON) confirmed she expected staff sending a resident to the hospital should get a signed bed hold from the resident or the resident representative. The facility policy titled Transfer or Discharge, Emergency dated 12/2016, lacked direction regarding the provision of written notification of bed hold upon hospitalization.	F 625	Corrective Action as it applies to others: Bed Hold Notice for Hospital Transfer and Therapeutic Leave form/policy was reviewed and remains current. It does state that a copy of the signed bed hold would be provided to resident or resident representative if requested. All residents who have been in the hospital in the last month will have bed holds completed and on file. All nurses will be educated on the requirement of completing a bed hold before a resident goes on an LOA or to the hospital. Social Services will be educated to ensure that bed hold was obtained at transfer, and if not, obtain bed hold at that time. Date of Compliance: 02/14/2022 Recurrence will be prevented by: Audit all residents that are transferred to the hospital or on an LOA to ensure a bed hold was completed correctly weekly x4 weeks then monthly for 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	
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring	F 678		2/14/22

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F 678	Continued From page 8 such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure documentation of each resident's advance directive/code status was consistent throughout their records to ensure the code status reflected resident current resuscitation preferences and physician orders. The facility's failure resulted in an immediate jeopardy, risk of serious harm, injury, or impairment for 1 of 25 residents (R21) reviewed for advance directives. The immediate jeopardy began on 1/19/22, when it was identified R21 had changed her preference from requesting cardiopulmonary resuscitation (CPR) to do not attempt resuscitation (DNR). R21's electronic medical record (EMR) and POLST listed discrepancies in R21's most current code status and the facility lacked a system to ensure changes were reflected in the residents current record. The associate administrator and the director of nursing (DON) were notified of the IJ on 1/19/22, at 3:26 p.m. The IJ was removed at 10:48 a.m. on 1/20/22, but noncompliance remained at the lower scope and severity of D-pattern, with no actual harm but potential for more than minimal harm. Findings include: R21's Admission Report printed on 1/19/22, indicated R21's diagnoses included hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid	F 678	F678 Cardio-Pulmonary Resuscitation Immediate Corrective Action: R21's code status on PCC dashboard and care plan was reviewed and updated per POLST on 1/19/22. Corrective Action as it applies to others: POLST Documentation policy was reviewed and remains current. Audit completed on 1/19/22 on all residents' PCC dashboard and care plans to ensure current POLST preference matched. Verbal education was completed on 1/19/22 with the DON, RN Manager, Admissions RN, and LPN Care Coordinator regarding POLST Documentation policy, facility POLST process and the need to complete a second check upon admission or with any POLST change to ensure residents POLST preference is reflected on the PCC dashboard and care plan. Education with Social Worker that POLST is to be completed by Clinical leader only. Date of Compliance: 02/14/2022 Recurrence will be prevented by: Audit all new admissions to ensure POLST and PCC match and are	

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F 678	Continued From page 9 hormone), arthropathy (disease of the joint) of right shoulder, opioid dependence (physical and psychological reliance on opioids, a substance found in certain prescription pain medications), and depression. R21's admission Minimum Data Set (MDS) dated 11/29/21, indicated R21 had moderate cognitive impairment. On 1/18/22, at 7:20 p.m. R21's EMR was reviewed which revealed the following: -R21's physician orders dated 11/22/21, listed orders for CPR. -R21's code status located in the EMR banner indicated R21's code status was CPR (cardiopulmonary resuscitation). -R21's POLST was found in the EMR under the miscellaneous tab. The POLST indicated R21's code status was do not resuscitate (DNR). The POLST was signed by R21 and social services (SS)-A on 11/23/21, and signed by the provider/nurse practitioner on 11/30/21. On 1/19/22, at 8:21 a.m., licensed practical nurse (LPN)-A stated she would look in the EMR banner to see if a resident wanted CPR or DNR. On 1/19/22, at 8:22 a.m. the director of nursing (DON) verified the resident's code status would be found in the EMR banner, in the resident's orders, and the POLST would be found in the scanned documents. On 1/19/22, at 9:47 a.m. R21 stated when she first came to the facility she wanted to be a full code (CPR), but then changed her mind to be DNR. R21 verified her current wishes were for DNR.	F 678	completed weekly x4 weeks then monthly for 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 678	Continued From page 10 On 1/19/22, at 9:53 a.m. registered nurse (RN)-A reported code status was identified in the EMR banner and staff checked this for area for a resident's code status. RN-A stated orders for code status were entered by the admitting nurse. R21's code order had been entered on 11/22/21, by RN-B as CPR. RN-A verified R21's code status in the EMR was incorrectly listed as CPR on the banner and in the orders, based on R21's current POLST. On 1/19/22, at 11:27 a.m. during follow up interview, the DON stated resident code status was reviewed quarterly at each resident's care conference, annually and anytime a resident would request a change to their POLST. The DON verified the order for R21's code status did not reflect R21's current wishes. On 1/19/22, at 11:47 a.m. RN-B stated the POLST was part of the admission packet and was reviewed on admission with the admitting nurse helping the resident to fill the POLST out. Once the admitting nurse knew the resident's choice for code status the order was added, and this step generated the code status in the EMR banner. RN-B stated she thought another nurse would check to ensure the order was entered correctly. RN-B recalled during R21's admission process, R21 wanted to talk with her daughter about code status. RN-B stated she then deferred the matter to the clinical manager (RN-A) and didn't remember entering R21's code status order. On 1/19/22, at 12:10 p.m. social service (SS)-A stated POLST's were generally filled out by nursing, and she would make the code status	F 678		

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F 678	Continued From page 11	F 678		

entry in the care plan. Although R21's POLST was signed by SS-A, she could not recall any details about why she helped R21 fill out the form. SS-A stated the order for code status was put in by health information staff.

On 1/19/22, at 12:13 p.m. during a group interview with DON and RN-A, DON stated the POLST order was to be completed by the admitting nurse. The DON stated there should have been a double check of the order by another nurse. RN-A stated she could not say that orders were always checked by another nurse 100% of the time. Both the DON and RN-A stated there was no system in place to verify a double check was completed after entering a POLST order.

On 1/21/22, at 9:51 a.m. R21's medical doctor (MD)-A verified she would have expected the facility to have processes in place to ensure resident's resuscitation status was accurate and reflected the resident's current wishes.

The facility policy titled POLST Documentation dated 1/29/20, indicated code status would be discussed with the resident and/or resident representative upon admission and would be entered into the individualized plan of care/electronic medical record and communicated throughout the facility, so staff would know what actions to take in an emergency. The facility policy did not address how changes would be made should the resident wish to change their code status.

The IJ was removed on 1/20/22, at 10:48 a.m. when it was verified the facility had reviewed all the residents records to ensure the banner and order reflected the resident's most current

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F 678	Continued From page 12 POLST. In addition, the facility reviewed the policy titled POLST Documentation dated 1/29/20. A process for completing a POLST and obtaining a physician order to reflect the resident's current POLST preference was developed. The process was to be completed by the DON, the nurse manager, the LPN care coordinator, medical records, or admission nurse. In addition, the the process included a step that required a check by a second staff person (from the staff already listed) for accuracy. The second staff person would initial the original POLST when they verified the order was accurately entered. In addition, social services would no longer be completing a POLST. The staff involved with the POLST process were educated on 1/20/22. This information was verified with the DON, SS-A and three licensed staff on 1/20/22, between 9:38 a.m. and 10:30 a.m.	F 678		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure skin issues were reported and followed up on for 1 of 1 resident (R16) reviewed for skin issues. In addition the facility failed to follow up with after	F 684	F684 Quality of Care Immediate Corrective Action: Resident 16's skin concern was addressed.	2/14/22

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F 684	Continued From page 13 care following an emergency room visit for 1 of 1 resident (R53) reviewed for emergency room care. Findings include: R16's admission record printed on 1/21/22, indicated R16's diagnoses included cerebral infarction (stroke), heart failure (a chronic condition in which the heart does not pump blood as well as it should), and anxiety. R16's quarterly Minimum Data Set (MDS) dated 11/9/21, indicated R16 was severely cognitively impaired. In addition, R16 required extensive to total assistance with his activities of daily living and was always incontinent of bowel and bladder. R16's care plan initiated on 10/5/20, indicated R16 was at risk for skin breakdown. Interventions included monitoring skin daily, document weekly skin inspections, and keep provider informed of skin issues. In addition, R16's Order Summary Report printed on 1/21/22, indicated R16 had orders dated 1/14/22, for skin inspections to be done by a licensed nurse weekly. R16's weekly skin inspections were requested but not provided. On 1/18/21, at 6:06 p.m. R18 was observed in his room lying on his bed, his legs were uncovered. A red, raised area on his left thigh was noted. On 1/21/22, at 9:17 a.m. nursing assistant (NA)-F stated she had performed morning cares and dressed R16 that morning. NA-F said she saw	F 684	Resident 53's nose packing was removed. Corrective Action as it applies to others: Skin assessment and wound management policy reviewed and remains current. Medication orders policy was reviewed and remains current. All current residents skin assessed to ensure no concerns are noted. All current resident's treatment orders were reviewed and are up to date. Nursing staff were educated on making sure if a resident has skin concerns that the nurse is updated right away so they can document the concern. DON, NM, and other management nurses were educated on ensuring that all orders are placed in PCC to ensure they are followed. Date of Compliance: 02/14/2022 Recurrence will be prevented by: Audit 5 residents for any skin concerns to ensure they were documented and being addressed weekly x4 weeks then monthly for 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. Audit 5 residents with new treatment orders to ensure they are in ETAR weekly x4 weeks then monthly for 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or	

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F 684	Continued From page 14 "scratch marks" on his thigh but she did not inform the nurse. NA-F did not indicate how long they had been there or why she did not inform the nurse. On 1/21/22, at 10:08 a.m. licensed practical nurse (LPN)-B looked at R16's left thigh and said it looked as if he had been scratching his leg. LPN-B stated he had red raised areas along his left thigh. LPN-B verified she had not been informed by the nursing assistants about R16's skin, but would expect them to tell her about any skin issues. On 1/21/22, at 12:21 p.m. the director of nursing (DON) stated the NAs are trained to inform nurses if they see any skin issues. The DON verified she would expect them to inform the nurses of scratches or red raised areas. The facility policy titled Skin Assessment and Wound Management dated 7/2018, directed staff to notify the nurse manager of non-pressure skin concerns, update the care plan, and document weekly. R53's admission record, undated, indicated diagnoses of diabetes, history of pulmonary embolism, hypertension, and peripheral vascular disease. R53's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/9/21, indicated R53 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated the resident was cognitively intact. R53's progress notes dated 1/15/22, to 1/16/22,	F 684	discontinue the audit. Corrections will be monitored by: Director of Nursing or Designee	

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F 684	Continued From page 15	F 684		

indicated R53 refused his scheduled Coumadin (blood thinning medication) on 1/15/22, due to a persistent nosebleed. The progress notes indicated on 1/16/22, at 12:52 a.m. R53 was transferred to the emergency room (ER) for evaluation due to the nosebleed persisting and facility interventions being unsuccessful. R53 returned to the facility on 1/16/22, at 8:07 a.m. with a "rhino rocket" (type of dressing inserted in the nostril specifically designed for epistaxis/nosebleeds) in the right nostril. The progress note documented the ER instructions indicated the rhino rocket was to remain in place for a few days, R53's Coumadin was ordered to be held on 1/16/22, and the nurse had placed the ER discharge paperwork in the office of registered nurse (RN)-A.

R53's January 2022 medication administration record (MAR), indicated the Coumadin orders were updated on 1/16/22, to hold the dose for 1/16/22; however, there was no documentation regarding the removal of the rhino rocket.

R53's EMR orders revealed no new orders were added related to the removal of the rhino rocket when R53 returned from the hospital on 1/16/22.

During an observation on 1/18/22, at 1:30 p.m., R53 was self-propelling his wheelchair in the facility with the rhino rocket in place in his right nostril.

During an interview on 1/18/22, at 6:45 p.m. R53 stated approximately three to four days ago he experienced excessive nosebleeds. R53 stated the facility sent him out to the hospital for evaluation, he spent the night, and returned the next day with a rhino rocket in his right nostril.

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F 684	Continued From page 16	F 684		

During the interview, the rhino rocket was no longer in R53's right nostril. R53 stated "I asked [RN-A] earlier today to remove it since it's already been in for three days, and the ER said it needed to be out after two days" but she did not remove it at that time. R53 further stated that he got tired of waiting for RN-A, stating, "I saw her [RN-A] earlier and she told me she hadn't forgotten, but she must have and so I took it out myself".

During an observation on 1/18/22, at 7:20 p.m. a conversation was heard between RN-A and licensed practical nurse (LPN-A) regarding R53's rhino rocket. RN-A asked, "Do you know how to remove a nose packing?" LPN-A answered "Yes, who needs one out?" RN-A then stated R53 needed his removed. LPN-A replied that it was already out. RN-A asked LPN-A who took it out and LPN-A stated, "I don't know, it was out about 45 minutes ago when I saw him."

During an interview on 1/18/22, at 7:30 p.m. LPN-A stated that she was unaware R53 had any orders for when to remove the rhino rocket.

During an interview on 1/20/22, at 3:00 p.m. RN-A she stated when a resident left the facility for an appointment or returned from the hospital, the paperwork was reviewed by the nurse, and then given to her (RN-A), or the unit secretary. RN-A stated she would make a note in the resident record indicating any changes, and the unit secretary uploaded/scanned the documents into the EMR. RN-A reported the unit secretary "...was out currently with COVID..." and some documents for the past few weeks had not been scanned into the EMR.

During an interview on 1/21/22, at 9:50 a.m. RN-A

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F 684	Continued From page 17 stated she was aware R53 took the rhino rocket out on his own and stated she didn't "get to it, and he did it on his own." RN-A confirmed R53 should not have taken it out by himself. RN-A also stated the ER discharge paperwork was probably in her upload pile as she was behind since she was the only clinical manager and the unit secretary was out sick. RN-A confirmed the removal of the rhino rocket should have been added to the Treatment Administration Record (TAR) when R53 returned from the ER, and the floor nurse could have removed it. During an interview on 1/21/22, at 10:15 a.m. RN-A stated she was unable to locate the discharge paperwork from R53's ER visit on 1/16/22. RN-A stated she knew she saw it as she changed R53's Coumadin orders. However, RN-A was unable to find the actual paperwork. RN-A was unable to state exactly when the rhino rocket was ordered to be removed. On 1/21/22, at 12:00 p.m. the director of nursing (DON) stated the usual process was for the unit secretary to take any resident paperwork, scan, and upload into the EMR and then pass it onto RN-A for notification of any new orders. The DON also stated her expectation was for RN-A to review the discharge paperwork and implement the new orders. The facility policy and procedure Medication Orders, revised November 2014, indicated when recording treatment orders, specify the treatment, frequency and duration of the treatment.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		2/14/22

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F 689	Continued From page 18 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to implement physician orders and care planned interventions to prevent falls for 1 of 4 residents (R46) reviewed for falls. Findings include: R46's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/29/21, indicated R46 had severely impaired cognitive skills for daily decision making, and required total assistance from staff for most activities of daily living (ADLs). The MDS also indicated R46 had sustained two or more non-injury falls as well as one fall with injury (except major) since the prior assessment. R46 had a physician's order dated 7/6/21, that indicated to use gripper socks one time a day. R46's care planned interventions included but were not limited to: -ensure wheelchair (w/c) brakes are unlocked, dated 9/9/20; -if staff noting resident sitting in w/c and reaching for things on the floor, staff to provide alternate items of interest to the resident, dated 11/6/20; -Encourage to spend waking hours in areas	F 689	F689 Free of Accident Hazards/Supervision/Devices Immediate Corrective Action: Resident 46's gripper socks placed on feet per orders and intervention added to residents fall care plan. Corrective Action as it applies to others: The Fall Prevention and Management policy reviewed and remains current. All residents who have fallen in last 30 days will have their fall care plan reviewed to ensure all interventions are in place. Director of Nursing, Nurse Managers, Floor Nurses, and Infection Preventionist were educated on ensuring fall interventions are placed on the resident's care plan. Date of Compliance: 02/14/2022 Recurrence will be prevented by: Audit 5 residents that have fallen in last 30 days to ensure interventions are care planned and being followed weekly x4 weeks then monthly for 2 months. The results of the audits will be shared with the	

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F 689	Continued From page 19 where he can be observed, dated 7/17/20; and -setup activities such as laundry basket, tinker box and magazines, dated 12/22/20. The care plan did not include the 7/6/21, physician order for the use of gripper socks. On 1/19/22, at 9:56 a.m., R46 was observed at the end of the hall and leaning forward in his wheelchair as though he was working on something. R46 was wearing plain white socks. On 1/21/22, at 7:35 a.m., R46 was in his room sitting in his wheelchair. He had a bandage on his forehead above the left eye. He was wearing plain white socks. On 1/21/22, at 10:19 a.m., nursing assistant (NA)-B stated R46, would take off his gripper socks and put them in places. NA-B stated if he needed to wear them she would put them on. NA-B stated R46 would quickly lose interest in activities. On 1/21/22, at 10:35 a.m., licensed practical nurse (LPN)-B stated grippers socks were an early intervention, and she did not realize it was an order. LPN-B stated she monitored staff in following orders and the care plan by trusting her co-workers. LPN-B stated, "I trust co-workers. The CNAs know what they are supposed to do." On 1/21/22, at 12:03 p.m., registered nurse (RN)-A stated R46 "thinks he can get up and walk and when he tries, he will fall." RN-A agreed that staff should follow the care plan and the order for use of gripper socks should be included in in the care plan. RN-46 stated there had not been a fall meeting for quite some time and said there should always be new interventions added to the	F 689	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 689	Continued From page 20	F 689		

care plan after a fall.

On 1/21/22, at 10:03 p.m. the director of nursing (DON) stated falls were discussed in the morning meetings and clinical staff would come up with interventions which should be listed on the care plan. The DON confirmed there were no new interventions on R46's care plan. The DON stated R46 should be in grippers and this intervention should be on the care plan. The DON also stated she expected staff to do activities with R46 or to at least attempt them.

The facility policy titled Fall Prevention and Management dated 2/2021, indicated, "Policy Statement: The purpose of this protocol is to identify residents at risk for falls, implement fall prevention interventions, provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. . . Managing Falls and Fall Risk Facility staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on the nature of or type of fall, until falling is reduced or stopped or until the reason for the continuation of the falling is identified as unavoidable. Staff may also identify and implement relevant interventions to try to minimize serious consequences of falling. Staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. . ."

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F 695	Continued From page 21	F 695		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to clean respiratory equipment for 2 of 4 residents (R40 and R51) reviewed for oxygen therapy. Findings include: R40's Face Sheet undated, indicated R40 had diagnoses of chronic obstructive pulmonary disease (COPD; a chronic inflammatory lung disease), obstructive sleep apnea, and congestive heart failure. R40's had a physician order dated 6/10/21 for oxygen at 0-3 lpm [liters per minute] to keep sats [oxygen saturation] greater 90% every shift. On 1/18/22, at 4:26 p.m., R40's concentrator was observed with one filter on the back of the machine. The filter had a thick coating of dust. R51's Face Sheet undated, indicated R51 had diagnoses which included COPD, pulmonary embolism, shortness of breath, obstructive sleep	F 695	F695 Respiratory/ Tracheostomy Care and Suctioning Immediate Corrective Action: Resident 40's concentrator filter was cleaned. Resident 51's concentrator filter was cleaned. Corrective Action as it applies to others: The Oxygen General Guidelines policy was reviewed and remains current. All residents that have oxygen concentrators were assessed to ensure filters are clean and orders are in EMAR to clean weekly. All nursing management was educated on ensuring orders are placed in the EMAR to clean filters for any residents using oxygen concentrator. Nurses/TMAs were educated to clean filters as directed by EMAR. Date of Compliance: 02/14/2022	2/14/22

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F 695	Continued From page 22 apnea, and emphysema. R51 had a physician order dated 12/14/21, for: oxygen to keep sats greater 90%. Check O2 [oxygen] sats and document if needs oxygen every shift related to chronic obstructive pulmonary disease. On 1/18/22, at 6:02 p.m., R51's concentrator was observed with one filter on the back of the machine. The filter had a thick coating of dust. During an interview on 1/21/22 at 7:43 a.m., licensed practical nurse (LPN)-B was shown the concentrators and the dust covered filters. LPN-B confirmed the filters were dusty for both concentrators (R40 and R51) and stated, "Nursing should clean the filters. The filters should be cleaned on bath days. The computer should trigger us." LPN-B looked in the computer and stated, "It is not in the computer to trigger us." During an interview on 1/21/22 at 11:46 a.m., registered nurse (RN)-A stated staff rely on the Medication Administration Record (MAR) to trigger the weekly filter cleaning. During an interview on 1/21/22 at 2:06 p.m., the director of nursing (DON) stated staff should wipe the concentrator and wash the filter weekly. The DON stated the order was in the computer to trigger and schedule the cleaning. The DON then reviewed the EMRs for R40 and R51 and confirmed the order to trigger staff to wash the filters was not in the computer for these residents.	F 695	Recurrence will be prevented by: Audit all residents that have oxygen concentrators to ensure they have been cleaned and orders to do so are in the EMAR weekly x4 weeks then monthly for 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 695	Continued From page 23 The facility's Oxygen General Guidelines," policy dated 9/2011, indicated respiratory therapies were used in the facility to provide comfort for the resident with difficulty breathing and inability to maintain reasonable levels of oxygen in the blood without added oxygen, to maintain patent airways and assure resident respiratory status. Review of manufacturers' recommendations for the facility's oxygen concentrators revealed on page 17 under "Filter . . . At least one time each week, wash the air intake gross particle filter, which is located in the back of the unit. Your Equipment Provider may advise you to clean it more often, depending upon your operating conditions. Follow these steps to properly clean the air intake filter: 1. Remove the filter and wash it in a warm solution of soap and water. 2. Rinse the filter thoroughly, and remove excess water with a soft, adsorbent towel. Ensure that the filter is dry before replacing it. 3. Replace the dry filter. . ."	F 695		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.	F 712		2/14/22

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F 712	Continued From page 24 §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure newly admitted residents received 30-day physician visits for the first ninety days after admission for 1 of 3 residents (R53) reviewed for 30 day physician visits. Findings include: R53's Face Sheet printed 1/27/22, indicated R53 was admitted to the facility on 12/3/21, with diagnoses including a surgical wound, encounter for orthopedic aftercare following a surgical amputation and presence of a cardiac defibrillator. R53's census record in the electronic medical record (EMR) indicated R53 was initially admitted to the facility on 10/21/21, and left against medical advice (AMA) on 11/6/21. The EMR also indicated R53 returned to the facility on 12/3/21 and had remained there as a resident. Finally, R53's EMR indicated R53's physician had examined R53 on 10/21/21, but no other physician visits had been made before or after his AMA leave. In an email dated 1/26/22, at 2:06 p.m., the regional nurse consultant (RNC) confirmed R53 left AMA on 11/5/21, and returned on 12/3/21. The RNC also confirmed he had not had a	F 712	F712 Physician Visits- Frequency/ Timeliness/Alt Immediate Corrective Action: Resident 53 left AMA from facility prior to his scheduled MD visit. Corrective Action as it applies to others: The Physician Visits policy was reviewed and remains current. All current residents reviewed to ensure they have been seen by a physician per policy. Health Information and Nursing leadership educated on the Physician Visits policy. Date of Compliance: 02/14/2022 Recurrence will be prevented by: Audit 5 residents to ensure they have been seen by a physician per policy weekly x4 weeks then monthly for 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 712	Continued From page 25 physician visit since his return. The facility policy Physician Visits, revised 4/13, indicated the attending physician must visit his/her patients at least once every thirty days for the first ninety days follow the resident's admission.	F 712		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		2/14/22

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F 758	Continued From page 26 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consents were obtained for 1 of 5 residents (R34) reviewed for psychotropic drugs. In addition, the facility failed ensure a proper diagnosis and identify target behaviors for 1 of 5 residents (R24) reviewed for psychotropic drugs. Findings include: R 34's Admission Record printed on 1/20/22, indicated R34's diagnoses included schizophrenia, dementia with behavioral disturbances, insomnia, anxiety disorder, hallucinations, depression, and chronic pain. R34's quarterly Minimum Data Set (MDS) dated 12/10/21, indicated R34 had moderately intact cognition and was usually able to be understood	F 758	F758 Free from Unnec Psychotropic Meds/PRN Use Immediate Corrective Action: Resident 34 has all psychotropic consents completed. Resident 24's diagnosis was changed for her Seroquel order. Corrective Action as it applies to others: The Informed Consent for Required Medications policy was reviewed and remains current. The Medication Regimen Review policy was reviewed and remains current. The Pharmacy Services- Role of the Consultant Pharmacist was reviewed and remains current. The Psychotropic Medication Use was	

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F 758	Continued From page 27 and to understand others. R34's MDS indicated R34 had physical behaviors one to three days and other behaviors not directed at others daily. R34's MDS indicated he received antipsychotic, antianxiety, and antidepressant medications on a routine basis. R34's care plan initiated on 10/29/19, indicated R34 received high risk/antipsychotic medications and directed nursing to educate resident and resident representative on risk/benefit, and side effects of medications, monitor and document side effects and effectiveness, identify non-pharmacological interventions and implement, in addition target behaviors were identified. R34's Order Summary Report printed on 12/20/22, directed staff to monitor R34 for effectiveness of behavior interventions, dated 4/13/21. In addition, to monitor for target behaviors dated 10/29/19, and to monitor for side effects of antipsychotic medications dated 4/13/21. R34's Order Summary Report indicated R34 had orders for the following medications: -Ativan, used to treat anxiety dated 4/13/21. -Caplyta, used to treat hallucinations dated 4/13/21. -Cymbalta, used to treat depression dated 4/13/21. -Depakote, used to treat impulsivity related to anxiety disorder dated 4/13/21. -Olanzapine, used to treat agitation, yelling voices related to schizophrenia dated 4/13/21. -Risperdal, used to treat schizophrenia dated 6/24/20. -Trazadone, used to treat sleeplessness dated 4/13/21.	F 758	reviewed and remains current. All residents with psychotropic medications will be reviewed to ensure all consents have been obtained and diagnosis are appropriate for the medication being given. Nursing management was educated on ensuring psychotropic consents are obtained upon admission and the diagnosis supporting the medication is appropriate. Consultant Pharmacist was educated on the facility policy regarding the Role of the Consultant Pharmacist. Date of Compliance: 02/14/2022 Recurrence will be prevented by: Audit 5 residents to ensure psychotropic medications have consents and appropriate diagnoses weekly x4 weeks then monthly for 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 of Designee	

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R34's medical record identified consents for high risk/psychotropic use were last obtained in 2019. An attempt was made on 9/15/20, the facility mailed a consent to the resident's representative but failed to follow up when the consent was not signed and returned.

On 1/21/22, at 12:32 p.m. the director of nursing (DON) verified she would expect the facility to obtain a consent for high risk/psychotropic medication use annually and to follow up on consents that are mailed to resident representatives.

On 1/21/22, at 2:21 p.m. the consulting pharmacist verified he was not tracking high risk/psychotropic medication consents annually but stated maybe this was something he should include in his duties.

The facility form titled Informed Consent for Required Medications dated 10/2013, did not address the frequency of obtaining consent for high risk/psychotropic medications.

The facility policy titled Medication Regimen Review dated 5/2019, did not address obtaining signed consents for high risk/psychotropic medications.

R24's electronic medical record (EMR) dated 9/14/21, indicated R24 was admitted with diagnoses of malignant neoplasm of part of the bronchus or lung (lung cancer), anxiety disorder, and vascular dementia without behavioral disturbance.

R24's significant change Minimum Data Set

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(MDS) with an Assessment Reference Date (ARD) of 11/23/21, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. The MDS showed R24 did not display behaviors during the review period and had no change in behaviors since the previous assessment. The assessment also indicated R24 received an antipsychotic medication on seven of seven days of the review period.

R24 had a physician order dated 9/20/21, for quetiapine fumarate (Seroquel) Tablet 25 MG (milligram); give 0.5 tablet by mouth at bedtime related to vascular dementia without behavioral disturbance.

R24's progress notes dated 9/14/21, and 9/15/21, indicated R24 was forgetful at times and had difficulty falling asleep, but there was no indication R24 displayed uncontrolled behaviors.

R24's consultant pharmacist monthly medication regimen review (MRR) titled Summary Report for October 2021, November 2021, and December 2021 indicated under recommendations, "No irregularities identified."

During an interview on 1/21/22, at 9:19 a.m. R24 was asked if she knew why she was receiving the medication Seroquel (an atypical antipsychotic medication). R24 stated, "Seroquel helps me sleep." When asked if R24 had used the medication before coming into the facility, R24 stated, "I was on nothing when I was home."

During an interview on 1/21/22, at 10:31 a.m. licensed practical nurse (LPN)-B stated R24 was taking an antipsychotic medication for anxiety; but

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added, "I'm not sure. When asked why someone would be on an antipsychotic, LPN-B stated, "I'm drawing a blank. A mood stabilizer, but I'm not aware of a diagnosis of mood disorder for [R24]."

During an interview on 1/21/22, at 11:53 a.m. registered nurse (RN)-A stated R24 took an antipsychotic for dementia and for sleep RN-A was asked if those were appropriate diagnoses for the antipsychotic medication. RN-A stated it had been a while since there had been a meeting in which antipsychotics were discussed.

During an interview on 1/21/22, at 2:15 p.m., the director of nursing (DON) was asked about R24's antipsychotic medication usage. The DON looked in the EMR and stated, "Dementia. We need a different diagnosis. I expected the pharmacist to catch this. I don't see that he made any recommendations." The DON was asked if Seroquel for the diagnosis of dementia would be considered an unnecessary medication. The DON agreed it was an unnecessary medication.

During an interview on 1/21/22, at 2:45 p.m., the consultant pharmacist (CP) stated there were usually associated behaviors with the use of an antipsychotic medication. The CP stated there was no diagnosis and no behaviors that would indicate a need for R24 to be treated with an antipsychotic medication. The CP stated, "I should have caught this."

The facility policy titled Pharmacy Services- Role of the Consultant Pharmacist revised 4/2019, indicated the facility shall have the services of a consultant pharmacist and the consultant pharmacist would provide specific activities related to medication regimen review including:

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appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record.

The facility policy titled Psychotropic Medication Use undated, indicated psychotropic medications may be considered for residents in which symptoms have been identified and the interdisciplinary team has deemed would benefit from use of these meds. Psychotropic medication types can include, but are not limited to antidepressants, anti-anxiety medications, stimulants, antipsychotics, and mood stabilizers. Implementation of the policy indicated:
-residents would only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective;
-the interdisciplinary team and the primary provider would gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others;
-the interdisciplinary team and the primary provider would identify, evaluate, and document, symptoms that may warrant the use of psychotropic medications;
-diagnosis of a specific condition for which psychotropic medications are necessary to treat would be based on a comprehensive assessment of the resident. . .
-antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical

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F 758	Continued From page 32 Manual of Mental Disorders (current or subsequent editions): a. Schizophrenia; b. Schizo-affective disorder; c. Schizophreniform disorder; d. Delusional disorder; e. Mood disorders (e.g. bipolar disorder, severe depression refractory to other therapies and/or with psychotic features); f. Psychosis in the absence of dementia; g. Medical illnesses with psychotic symptoms (e.g., neoplastic disease or delirium) and/or treatment related psychosis or mania (e.g., high-dose steroids); h. Tourette's Disorder; i. Huntington Disease; j. Hiccups (not induced by other medications); or k. Nausea and vomiting associated with cancer or chemotherapy. l. Behavioral or psychological symptoms of dementia (BPSD) that present a danger to the resident or others.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free of significant medication errors for 1 of 1 residents (R34) reviewed for insulin administration. Findings include: R34's Admission Record printed on 1/20/22, indicated R34's diagnoses included type two Diabetes Mellitus. R34's quarterly Minimum Data Set (MDS) dated	F 760	F760 Residents are Free of Significant Med Errors Immediate Corrective Action: Resident 34 got the correct dose of insulin. Corrective Action as it applies to others: The Lantus Manufacturer Brochure was reviewed. All residents who get insulin administered with pens were assessed to ensure insulin is being given correctly.	2/14/22

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F 760	Continued From page 33 12/10/21, indicated R34 had moderately intact cognition and was usually able to be understood and to understand others. R34's MDS indicated he was receiving insulin injections daily. R34's Order Summary Report as of 1/20/22, indicated R34 had orders for insulin glargine 16 units inject subcutaneously two times a day related to type two Diabetes Mellitus order date 4/13/21. On 1/20/22, at 8:15 a.m. licensed practical nurse (LPN)-D took out R34's glargine insulin pen removed the cap and dialed 16 units. LPN-D then removed an alcohol swab, cleaned the top of the insulin pen and placed an insulin needle on the pen. LPN-D brought R34 to his room, checked his blood sugar, and administered the insulin. LPN-D did not prime the insulin needle. On 1/20/22, at 1:24 p.m. LPN-D verified he dialed up the 16 units of insulin prior to placing an insulin needle on the insulin pen. LPN-D verified he did not prime the insulin needle with two units of insulin and then dial up the insulin. LPN-D stated he was not aware of the need to prime the insulin needle prior to dialing up the insulin. On 1/21/22, at 12:28 p.m. the director of nursing verified she would expect staff to prime the insulin needle with two units of insulin prior to dialing up the insulin dose to ensure the resident received the correct insulin dose. The facility policy titled Insulin Administration no date, did not address priming insulin needles with insulin pens.	F 760	All nurses were educated on how to use an insulin pen and return demonstration was completed to ensure competence. Date of Compliance: 02/14/2022 Recurrence will be prevented by: Audit of 2 nurses will be done to ensure competence with insulin pen administration weekly x4 weeks then monthly for 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	
F 880 SS=D	Infection Prevention & Control	F 880		2/14/22

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F 880	Continued From page 34 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; §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	F 880		

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F 880	Continued From page 35 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. §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 ensure proper hand hygiene and glove use practices were maintained for 1 of 1 residents (R33) observed during a dressing change. Findings include: R33's Admission Record printed on 1/21/22, indicated R33 had diagnoses which included a	F 880	F880 Infection Prevention and Control Immediate Corrective Action: Resident 33 had dressing changed using proper technique. Corrective Action as it applies to others: The Skin Assessment and Wound Management policy was reviewed and remains up to date.	

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F 880	Continued From page 36 pressure ulcer of right hip and paraplegia. R33's quarterly Minimum Data Set (MDS) dated 12/8/21, indicated R33 was cognitively intact and required extensive assistance with activities of daily living. R33's MDS indicated he had a stage three pressure ulcer and one unstageable pressure ulcer. R33's care plan initiated on 6/4/21, identified R33 had current pressure injuries to his right hip and right coccyx. Interventions included treatments to open areas per orders. R33's Order Summary Report printed on 12/21/22, directed staff to clean right hip wound with normal saline or wound cleanser. Cover with bordered foam daily. One time a day, ordered on 8/26/21. On 1/20/22, at 1:38 p.m. licensed practical nurse (LPN)-D donned his personal protective equipment (PPE); performed hand hygiene, donned an N-95 mask, performed hand hygiene, donned an isolation gown and put on gloves prior to entering R33's isolation room to perform a dressing change. In R33's room LPN-D gathered and prepared dressing change supplies. LPN-D removed R33's old dressing which had stool on the outside of the dressing. LPN-D then cleaned stool from the area, removed the packing from the wound and did not change gloves and did not perform hand hygiene. LPN-D then cleaned the coccyx wound with normal saline soaked gauze, repacked the coccyx wound wearing the same gloves and using his fingers, with gauze that was wet with normal saline. LPN-D then covered the dressing with a foam bordered dressing and placed a new brief on R33. LPN-D then doffed his	F 880	The Handwashing/ Hand Hygiene policy was reviewed and remains current. All residents will dressings assessed to ensure dressing changes were completed using hand hygiene and glove changes. All nurses were educated on how to change a dressing using hand hygiene and glove changes. Date of Compliance: 02/14/2022 Recurrence will be prevented by: Audit 2 nurses to ensure a dressing change is completed using proper technique with hand hygiene and glove changes weekly x4 weeks then monthly for 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 if Nursing or Designee	

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F 880	Continued From page 37 PPE and exited the room. LPN-D performed hand hygiene after exiting R33's room. On 1/20/22, at 1:45 p.m. LPN-D verified he did not change his gloves after removing the old dressing and before cleaning the wound. LPN-D stated he was not sure if he could remove/change gloves in a COVID-19 isolation room. On 1/21/22, at 12:25 p.m. the director of nursing (DON) verified she would expect staff to change gloves and perform hand hygiene after removing a dressing and before cleaning and packing a wound. The facility policy titled Skin Assessment and Wound Management dated 7/2018, directed staff to provide wound care utilizing safe and sanitary methods in an effort to prevent contamination or the spread of infection. The facility policy titled Handwashing/Hand Hygiene dated 8/2019, directed staff to use an alcohol-based rub or alternatively soap and water after before handling clean or soiled dressings, gauze pads, etc.; before moving from a contaminated body site to a clean body site. In addition the policy directed staff that the use of gloves did not replace hand washing/hand hygiene.	F 880		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by:	F 908		2/14/22

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F 908	Continued From page 38 Based on observation, interview, and review of the facility policy, the facility failed to ensure equipment used to provide care for residents were clean and maintained in good repair for 2 of 2 residents (R46 and R48) reviewed for maintenance. Specifically, observations revealed a pole utilized for tube feedings with a rusted base and a dried, white substance dripped down the pole as well as splattered on the base, and a wheelchair with a stained, frayed, and cracked/missing vinyl seat. Findings include: R46's care plan initiated on 2/22/20, indicated R46's diagnoses included dementia without behavioral disturbances. R46's quarterly Minimum Data Set (MDS) dated 12/29/21, indicated R46 had severely impaired cognition. In addition, R46 was totally dependent with ADLs and was always incontinent of bowel and bladder. During an observation on 1/18/22, at 2:17 p.m., R46 sat in the hallway in a wheelchair with pieces of vinyl missing from the edge of the seat and a split along the seam of the left arm, exposing the foam and cloth underneath. During an observation on 1/21/22, at 7:35 a.m., R46 was in his room in a wheelchair with pieces of vinyl missing from the edge of the seat and a split along the seam of the left arm, exposing the foam and cloth underneath. During an interview on 1/21/22, at 7:45 a.m., licensed practical nurse (LPN)-B stated the wheelchairs should be cleaned by the nursing	F 908	F908 Essential Equipment, Safe Operating Condition Immediate Corrective Action: Resident 46's wheelchair was repaired. Resident 48's tube feeding pole was replaced. Corrective Action as it applies to others: The Maintenance Service policy was reviewed and remains current. All residents with wheelchairs were assessed to ensure wheelchairs were in good repair. All residents with tube feeding were assessed to ensure tube feeding poles were in good repair. All staff educated on what to do if equipment needs to be repaired. All staff educated on cleaning up an area if it is soiled. Date of Compliance: 02/14/2022 Recurrence will be prevented by: Audit 5 residents wheelchairs to ensure in working order weekly x4 weeks then monthly for 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. Audit all residents tube feeding poles to ensure clean and in working order weekly x4 weeks then monthly for 2 months. The results of the audits will be shared with the facility QAPI committee for input on the	

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F 908	Continued From page 39 assistants on resident bath days. LPN-B stated she trusted that the staff were cleaning the wheelchairs and did not check on them. LPN-B stated the missing vinyl should have been reported to maintenance. During an interview on 1/21/22, at 2:36 p.m., environmental service director (ESD)-A stated rounds were completed monthly, and wheelchairs were reviewed during those rounds. ESD-A stated R46 always had something done to the wheelchair and they were doing some kind of repair every two weeks. ESD-A stated there was no documentation to show maintenance was performed to R46's wheelchair. R48's admission MDS dated 1/3/22, indicated R48's diagnoses included cardiorespiratory condition and seizure disorder. R48's MDS also indicated she had severely impaired cognition. In addition, R48 was totally dependent with activities of daily living (ADLs) and was always incontinent of bowel and bladder. During an observation on 1/18/22, at 3:20 p.m., R48 was laying in bed while receiving a tube feeding. The pole used for the feeding was next to the bed and had a bottle of liquid with tubing connected to the resident. The pole base was rust-colored where the wheels were attached and there was a white dried substance running down the pole and splattered on the base. During an observation on 1/19/22, at 8:45 a.m., R48 was in the communal area in a broda chair (type of specialized wheelchair). There was a pole next her with a bottle of liquid with tubing going to the R48. The pole base was rust-colored	F 908	need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Administrator/ Director of Nursing or Designee	

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where the wheels were attached and there was a white dried substance running down the pole and splattered on the base.

On 1/20/22, at 1:14 p.m., LPN-D propelled R48 back to her room with the pole used for her tube feedings. The base was noted to have rusted areas and the metal appeared to be peeling away. Drips of dried white substance were present on the pole with splattered residue noted on the base as well. LPN-D confirmed the pole was dirty and rust colored.

During an interview on 1/21/22, at 12:13 p.m., registered nurse (RN)-A stated work orders should be turned in for maintenance to work for wheelchairs with torn and missing vinyl. RN-A stated the nursing assistants were to clean the wheelchairs on bath days. RN-A stated she had not noticed the condition of R48's tube feeding pole, but it should be cleaned by the nursing staff and further stated it did not sound like it was appropriate for use with its current condition.

During an interview on 1/21/22, at 1:50 p.m., the director of nursing (DON) stated a work order should be put in for maintenance on a wheelchair with ripped or torn vinyl. The DON also stated nursing assistants should be cleaning the wheelchairs on the residents' bath day. The DON stated nurses were responsible for cleaning anything that was spilt on the tube feeding poles and if there was rust, the pole should not be used.

The facility policy titled Maintenance Service, with a revised date of 12/ 2009, indicated maintenance service shall be provided to all areas of the building, grounds and equipment.

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F 908	Continued From page 41 The Maintenance Department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.	F 908		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 4, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: WWVA11

Dear Administrator:

The above facility was surveyed on January 18, 2022 through January 21, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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
	00583	A. BUILDING: _____ B. WING _____	C 01/21/2022

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/18/22, through 1/21/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. In addition the following complaints were found to be UNSUBSTANTIATED: H5277089C (MN78781), H5277090C (MN78825), H5277091C (MN79366). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21290	MN Rule 4658.0710 Subp. 3 A AdmissionOrders & Physician Evaluations Subp. 3. Frequency of physician evaluations. A. A resident must be evaluated by a physician at least once every 30 days for the first 90 days after admission, and then whenever medically necessary. A physician visit is considered timely if it occurs within ten days after the date the visit was required. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure newly admitted residents received 30-day physician visits for the first ninety days after admission for 1 of 3 residents (R53) reviewed for 30 day physician visits. Findings include: R53's Face Sheet printed 1/27/22, indicated R53 was admitted to the facility on 12/3/21, with diagnoses including a surgical wound, encounter for orthopedic aftercare following a surgical amputation and presence of a cardiac	21290	Corrected	2/14/22

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21290	Continued From page 3 defibrillator. R53's census record in the electronic medical record (EMR) indicated R53 was initially admitted to the facility on 10/21/21, and left against medical advice (AMA) on 11/6/21. The EMR also indicated R53 returned to the facility on 12/3/21, and had remained there as a resident. Finally, R53's EMR indicated R53's physician had examined R53 on 10/21/21, but no other physician visits had been made before or after his AMA leave. In an email dated 1/26/22, at 2:06 p.m., the regional nurse consultant (RNC) confirmed R53 left AMA on 11/5/21, and returned on 12/3/21. The RNC also confirmed he had not had a physician visit since his return. The facility policy Physician Visits, revised 4/13, indicated the attending physician must visit his/her patients at least once every thirty days for the first ninety days follow the resident's admission. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee could ensure that adequate policy and procedures are developed to ensure residents are seen by their physician routinely. The facility could educate staff on these policies and perform routine evaluations of physician visits to ensure residents are seen by their provider timely. The facility could report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21290		

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21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and glove use practices were maintained for 1 of 1 residents (R33) observed during a dressing change.	21390	Corrected	2/14/22

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21390	Continued From page 5 Findings include: R33's Admission Record printed on 1/21/22, indicated R33 had diagnoses which included a pressure ulcer of right hip and paraplegia. R33's quarterly Minimum Data Set (MDS) dated 12/8/21, indicated R33 was cognitively intact and required extensive assistance with activities of daily living. R33's MDS indicated he had a stage three pressure ulcer and one unstageable pressure ulcer. R33's care plan initiated on 6/4/21, identified R33 had current pressure injuries to his right hip and right coccyx. Interventions included treatments to open areas per orders. R33's Order Summary Report printed on 12/21/22, directed staff to clean right hip wound with normal saline or wound cleanser. Cover with bordered foam daily. One time a day, ordered on 8/26/21. On 1/20/22, at 1:38 p.m. licensed practical nurse (LPN)-D donned his personal protective equipment (PPE); performed hand hygiene, donned an N-95 mask, performed hand hygiene, donned an isolation gown and put on gloves prior to entering R33's isolation room to perform a dressing change. In R33's room LPN-D gathered and prepared dressing change supplies. LPN-D removed R33's old dressing which had stool on the outside of the dressing. LPN-D then cleaned stool from the area, removed the packing from the wound and did not change gloves and did not perform hand hygiene. LPN-D then cleaned the coccyx wound with normal saline soaked gauze, repacked the coccyx wound wearing the same gloves and using his fingers, with gauze that was	21390		

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21390	Continued From page 6	21390		

wet with normal saline. LPN-D then covered the dressing with a foam bordered dressing and placed a new brief on R33. LPN-D then doffed his PPE and exited the room. LPN-D performed hand hygiene after exiting R33's room.

On 1/20/22, at 1:45 p.m. LPN-D verified he did not change his gloves after removing the old dressing and before cleaning the wound. LPN-D stated he was not sure if he could remove/change gloves in a COVID-19 isolation room.

On 1/21/22, at 12:25 p.m. the director of nursing (DON) verified she would expect staff to change gloves and perform hand hygiene after removing a dressing and before cleaning and packing a wound.

The facility policy titled Skin Assessment and Wound Management dated 7/2018, directed staff to provide wound care utilizing safe and sanitary methods in an effort to prevent contamination or the spread of infection.

The facility policy titled Handwashing/Hand Hygiene dated 8/2019, directed staff to use an alcohol-based rub or alternatively soap and water after before handling clean or soiled dressings, gauze pads, etc.; before moving from a contaminated body site to a clean body site. In addition the policy directed staff that the use of gloves did not replace hand washing/hand hygiene.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff follow hand hygiene and glove use practices with dressing changes. The Director of Nursing or designee could

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21390	Continued From page 7 educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 5 residents (R18,	21426	Corrected	2/14/22

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21426	Continued From page 8 R30, R43, R44, R45) received tuberculin skin testing (TST) or an Interferon-Gamma Release Assay (IGRA) blood tests for tuberculin (TB) risk factors and symptoms according to the Centers for Disease Control & Prevention (CDC) guidelines. In addition, 2 of 5 staff (associate administrator [AA]-B, licensed practical nurse [LPN]-A) did not receive their second TST. Findings include: R18's admission Minimum Data Set (MDS) dated 11/18/21, identified R18's admission date as 11/12/21. R18's medical record indicated the baseline screening for TB was completed on 11/12/21. The facility was not able to provide evidence of TSTs or IGRA blood test. R30's admission MDS dated 12/13/21, identified R30's admission date as 12/6/21. R30's medical record indicated the baseline screening for TB was completed on 12/6/21 . The facility was not able to provide evidence of TSTs or IGRA blood test. R43's admission MDS dated 12/21/21, identified R43's admission date as 12/15/21. R43's medical record indicated the baseline screening for TB was completed on 12/15/21. The facility was not able to provide evidence of TSTs or IGRA blood test. R44's admission MDS dated 12/27/21, identified R44's admission date as 12/21/21. R44's medical record indicated the baseline screening for TB was completed on 12/21/21. The facility was not able to provide evidence of TSTs or IGRA blood test. R45's admission MDS dated 12/27/21, identified	21426		

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21426	Continued From page 9	21426		

R45's admission date as 12/20/21. R45's medical record indicated the baseline screening for TB was completed on 12/20/21. The facility was not able to provide evidence of TSTs or IGRA blood test.

AA-B hired on 11/10/21, had a TST administered on 11/19/21, it was read on 11/22/21, as negative. A second TST was not completed.

LPN-A hired on 10/27/21, had a TST administered on 5/13/21, it was read on 5/15/21, as negative. A second TST was not completed.

On 1/21/21, at 10:45 a.m. LPN-E stated residents were being screened for TB but the facility had been out of the TB testing solution since mid-November of 2021. LPN-E stated they were going to ask the rounding physician for orders to complete the IGRA blood tests. LPN-E verified the facility had an infection control contact with the Minnesota Department of Health but that she had not reached out to them but thought the administrator had. LPN-E verified AA-B and LPN-A did not receive the second TST in the two step testing process.

On 1/21/21, at 12:40 p.m. the director of nursing (DON) stated the facility had a shortage of TB testing solution. They had reached out to their corporate office and the plan moving forward was to ask for TB testing prior to admission. As of the day of the interview the facility was going to ask the rounding provider for blood tests for residents who had not been tested on admission. The DON verified they should have moved to getting the IGRA test when they were not able to get the TB testing solution.

On 1/21/21, at 3:10 p.m. the consulting

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21426	Continued From page 10 pharmacist stated the pharmacy was not aware of any TB testing solution shortages and had not received any faxes from the facility for TB testing solution. The Facility Tuberculosis (TB) Risk Assessment Worksheet for Healthcare Settings Licensed by the Minnesota Department of Health completed on 3/25/21, directed staff to complete a baseline TB screening of patients at the time of admission. The Baseline TB screening included a two-step tuberculin skin test (TST or Mantoux) or single TB blood test (Interferon Gamma Release Assay or IGRA), TB symptom screen, and assessment of the patient's risk factors. The risk assessment directed staff for new employees to complete a baseline screening upon hire, which included two-step tuberculin skin test (TST or Mantoux) or single TB blood test (Interferon Gamma Release Assay or IGRA) and TB symptom screening. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all new employees and new admissions are tested for TB. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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21535	Continued From page 11	21535		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consents were obtained for 1 of 5 residents (R34) reviewed for psychotropic drugs. In addition, the facility failed ensure a proper diagnosis and identify target behaviors for 1 of 5 residents (R24) reviewed for psychotropic drugs. Findings include:	21535	Corrected	2/14/22

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21535	Continued From page 12 R 34's Admission Record printed on 1/20/22, indicated R34's diagnoses included schizophrenia, dementia with behavioral disturbances, insomnia, anxiety disorder, hallucinations, depression, and chronic pain. R34's quarterly Minimum Data Set (MDS) dated 12/10/21, indicated R34 had moderately intact cognition and was usually able to be understood and to understand others. R34's MDS indicated R34 had physical behaviors one to three days and other behaviors not directed at others daily. R34's MDS indicated he received antipsychotic, antianxiety, and antidepressant medications on a routine basis. R34's care plan initiated on 10/29/19, indicated R34 received high risk/antipsychotic medications and directed nursing to educate resident and resident representative on risk/benefit, and side effects of medications, monitor and document side effects and effectiveness, identify non-pharmacological interventions and implement, in addition target behaviors were identified. R34's Order Summary Report printed on 12/20/22, directed staff to monitor R34 for effectiveness of behavior interventions, dated 4/13/21. In addition, to monitor for target behaviors dated 10/29/19, and to monitor for side effects of antipsychotic medications dated 4/13/21. R34's Order Summary Report indicated R34 had orders for the following medications: -Ativan, used to treat anxiety dated 4/13/21. -Caplyta, used to treat hallucinations dated 4/13/21. -Cymbalta, used to treat depression dated 4/13/21.	21535		

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21535	Continued From page 13 -Depakote, used to treat impulsivity related to anxiety disorder dated 4/13/21. -Olanzapine, used to treat agitation, yelling voices related to schizophrenia dated 4/13/21. -Risperdal, used to treat schizophrenia dated 6/24/20. -Trazadone, used to treat sleeplessness dated 4/13/21. R34's medical record identified consents for high risk/psychotropic use were last obtained in 2019. An attempt was made on 9/15/20, the facility mailed a consent to the resident's representative but failed to follow up when the consent was not signed and returned. On 1/21/22, at 12:32 p.m. the director of nursing (DON) verified she would expect the facility to obtain a consent for high risk/psychotropic medication use annually and to follow up on consents that are mailed to resident representatives. On 1/21/22, at 2:21 p.m. the consulting pharmacist verified he was not tracking high risk/psychotropic medication consents annually but stated maybe this was something he should include in his duties. The facility form titled Informed Consent for Required Medications dated 10/2013, did not address the frequency of obtaining consent for high risk/psychotropic medications. The facility policy titled Medication Regimen Review dated 5/2019, did not address obtaining signed consents for high risk/psychotropic medications.	21535		

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R24's electronic medical record (EMR) dated 9/14/21, indicated R24 was admitted with diagnoses of malignant neoplasm of part of the bronchus or lung (lung cancer), anxiety disorder, and vascular dementia without behavioral disturbance.

R24's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/23/21, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. The MDS showed R24 did not display behaviors during the review period and had no change in behaviors since the previous assessment. The assessment also indicated R24 received an antipsychotic medication on seven of seven days of the review period.

R24 had a physician order dated 9/20/21, for quetiapine fumarate (Seroquel) Tablet 25 MG (milligram); give 0.5 tablet by mouth at bedtime related to vascular dementia without behavioral disturbance.

R24's progress notes dated 9/14/21, and 9/15/21, indicated R24 was forgetful at times and had difficulty falling asleep, but there was no indication R24 displayed uncontrolled behaviors.

R24's consultant pharmacist monthly medication regimen review (MRR) titled Summary Report for October 2021, November 2021, and December 2021 indicated under recommendations, "No irregularities identified."

During an interview on 1/21/22, at 9:19 a.m. R24 was asked if she knew why she was receiving the medication Seroquel (an atypical antipsychotic

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medication). R24 stated, "Seroquel helps me sleep." When asked if R24 had used the medication before coming into the facility, R24 stated, "I was on nothing when I was home."

During an interview on 1/21/22, at 10:31 a.m. licensed practical nurse (LPN)-B stated R24 was taking an antipsychotic medication for anxiety; but added, "I'm not sure. When asked why someone would be on an antipsychotic, LPN-B stated, "I'm drawing a blank. A mood stabilizer, but I'm not aware of a diagnosis of mood disorder for [R24]."

During an interview on 1/21/22, at 11:53 a.m. registered nurse (RN)-A stated R24 took an antipsychotic for dementia and for sleep RN-A was asked if those were appropriate diagnoses for the antipsychotic medication. RN-A stated it had been a while since there had been a meeting in which antipsychotics were discussed.

During an interview on 1/21/22, at 2:15 p.m., the director of nursing (DON) was asked about R24's antipsychotic medication usage. The DON looked in the EMR and stated, "Dementia. We need a different diagnosis. I expected the pharmacist to catch this. I don't see that he made any recommendations." The DON was asked if Seroquel for the diagnosis of dementia would be considered an unnecessary medication. The DON agreed it was an unnecessary medication.

During an interview on 1/21/22, at 2:45 p.m., the consultant pharmacist (CP) stated there were usually associated behaviors with the use of an antipsychotic medication. The CP stated there was no diagnosis and no behaviors that would indicate a need for R24 to be treated with an antipsychotic medication. The CP stated, "I should have caught this."

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21535	Continued From page 16 The facility policy titled Pharmacy Services- Role of the Consultant Pharmacist revised 4/2019, indicated the facility shall have the services of a consultant pharmacist and the consultant pharmacist would provide specific activities related to medication regimen review including: appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record. The facility policy titled Psychotropic Medication Use undated, indicated psychotropic medications may be considered for residents in which symptoms have been identified and the interdisciplinary team has deemed would benefit from use of these meds. Psychotropic medication types can include, but are not limited to antidepressants, anti-anxiety medications, stimulants, antipsychotics, and mood stabilizers. Implementation of the policy indicated: -residents would only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective; -the interdisciplinary team and the primary provider would gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others; -the interdisciplinary team and the primary provider would identify, evaluate, and document, symptoms that may warrant the use of psychotropic medications; -diagnosis of a specific condition for which psychotropic medications are necessary to treat	21535		

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21535	Continued From page 17 would be based on a comprehensive assessment of the resident. . . -antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions): a. Schizophrenia; b. Schizo-affective disorder; c. Schizophreniform disorder; d. Delusional disorder; e. Mood disorders (e.g. bipolar disorder, severe depression refractory to other therapies and/or with psychotic features); f. Psychosis in the absence of dementia; g. Medical illnesses with psychotic symptoms (e.g., neoplastic disease or delirium) and/or treatment related psychosis or mania (e.g., high-dose steroids); h. Tourette's Disorder; i. Huntington Disease; j. Hiccups (not induced by other medications); or k. Nausea and vomiting associated with cancer or chemotherapy. l. Behavioral or psychological symptoms of dementia (BPSD) that present a danger to the resident or others. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure high risk/psychotropic medications have an associated diagnosis and consents were received. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		

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21545	Continued From page 18	21545		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or	21545		2/14/22

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21545	Continued From page 19 resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free of significant medication errors for 1 of 1 residents (R34) reviewed for insulin administration. Findings include: R34's Admission Record printed on 1/20/22, indicated R34's diagnoses included type two Diabetes Mellitus. R34's quarterly Minimum Data Set (MDS) dated 12/10/21, indicated R34 had moderately intact cognition and was usually able to be understood and to understand others. R34's MDS indicated he was receiving insulin injections daily. R34's Order Summary Report as of 1/20/22, indicated R34 had orders for insulin glargine 16 units inject subcutaneously two times a day related to type two Diabetes Mellitus order date 4/13/21. On 1/20/22, at 8:15 a.m. licensed practical nurse (LPN)-D took out R34's glargine insulin pen removed the cap and dialed 16 units. LPN-D then removed an alcohol swab, cleaned the top of the insulin pen and placed an insulin needle on the pen. LPN-D brought R34 to his room, checked	21545	Corrected	

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21545	Continued From page 20 his blood sugar, and administered the insulin. LPN-D did not prime the insulin needle. On 1/20/22, at 1:24 p.m. LPN-D verified he dialed up the 16 units of insulin prior to placing an insulin needle on the insulin pen. LPN-D verified he did not prime the insulin needle with two units of insulin and then dial up the insulin. LPN-D stated he was not aware of the need to prime the insulin needle prior to dialing up the insulin. On 1/21/22, at 12:28 p.m. the director of nursing verified she would expect staff to prime the insulin needle with two units of insulin prior to dialing up the insulin dose to ensure the resident received the correct insulin dose. The facility policy titled Insulin Administration no date, did not address priming insulin needles with insulin pens. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff follow proper insulin administration when using insulin pens. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights	21830		2/14/22

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21830	Continued From page 21 Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the	21830		

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resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this

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21830	Continued From page 23 subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure timely notification to the physician of increased oxygen needs for 1 of 3 residents (R18) reviewed for respiratory care. Findings include: R18's Admission Record printed on 1/21/22, indicated R18 had diagnoses which included heart failure (a chronic condition in which the heart does not pump blood as well as it should), chronic obstructive pulmonary disease (COPD [a group of lung diseases that block airflow and make it difficult to breathe]), moderate persistent asthma, shortness of breath, and edema. R18's admission Minimum Data Set (MDS) dated 11/18/21, indicated R18 was cognitively intact, required extensive assistance with activities of daily living (ADLs), and required oxygen. R18's care plan initiated on 11/12/21, indicated R18 was at risk for an alteration in oxygen/gas exchange. Interventions included in R18's care plan were to monitor oxygen saturations as ordered and as needed, administer oxygen as ordered, and keep medical doctor (MD) informed of changes.	21830	Corrected	

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R18's physician orders dated 11/12/21, directed staff to use oxygen at one to two liter per minute as needed for dyspnea (shortness of breath) per nasal cannula, in addition staff were to notify the Medical Doctor (MD) if R18 needed an increase in oxygen above one to two liters longer than 24 hours. R18's physician orders dated 11/12/21, directed staff to check R18's oxygen saturations every shift related to COPD.

R18's treatment record indicated R18's oxygen saturations were checked every shift on January 1, 2, 3, 4, 6, 7, 8, 9, 10, 12, 13, 14, 16, 17, 18, and 19, 2022, with no indication of how many liters of oxygen she was on. On January 5, 11, and 15, 2022, R18's oxygen saturations were checked on two of the three shifts, again with no indication of amount of oxygen used.

R18's progress note dated 1/15/22, at 1:51 a.m. indicated R18 was confused, agitated, and restless. The note indicated she was repeatedly removing her oxygen. The note indicated once R18 left her oxygen on (no indication of how many liters of oxygen were in use) her oxygen saturations were up to 90%. No indication the MD was notified.

R18's progress note dated 1/12/22, at 1:33 p.m. indicated R18's oxygen saturations were 76% on three liters of oxygen. Oxygen was increased to four liters of oxygen and R18 was encouraged to take deep breaths, the note indicated R18's oxygen saturations were 95%. Oxygen was decreased to three liters and oxygen saturations remained in the 90's. Nothing in the progress note indicated the MD had been notified.

R18's progress note dated 1/12/22, at 1:20 p.m. indicated R18 was having dyspnea and

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complaining of abdominal pain, her oxygen was at one liter and her oxygen saturation was 75%. R18's oxygen was increased to three liters, she was given pain medication and maintained oxygen saturations around 90%. The note indicated the clinical manager was notified but there was no indication the MD was notified.

On 1/20/22, at 9:14 a.m. R18 was observed wearing nasal cannula, her oxygen was set at 3.5 liters per minute.

On 1/20/22, at 3:52 p.m. licensed practical nurse (LPN)-C verified R18's oxygen was set at 3.5 liters per minute. LPN-C stated she had not received any report from the previous shift about an increase in oxygen for R18. LPN-C was not sure when the increase in oxygen had taken place or if it had been reported to R18's MD. LPN-C stated she was going to talk to her clinical manager to see what to do.

R18's progress note dated 1/20/22, at 4:23 p.m indicated R18's provider was notified about her oxygen saturations and her increased need for oxygen.

R18's physician orders were updated on 1/20/22, to increase her oxygen to one to four liters as needed to keep her oxygen saturations greater than 90%.

On 1/21/22, at 9:54 a.m. physician (P)-C verified she was first notified of R18's increased oxygen needs on 1/20/22. P-C verified she would have expected staff to notify her of R18's increased oxygen needs as per the order of 11/12/21.

On 1/21/22, at 12:15 p.m. the director of nursing (DON) verified she would expect staff to contact

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	00583	A. BUILDING: _____ B. WING _____	C 01/21/2022

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) COMPLETE DATE
21830	Continued From page 26 the physician of a resident's increased need for oxygen as ordered. The DON verified the shift documentation did not indicate how many liters of oxygen were in use. The facility policy titled Oxygen General Guidelines dated 9/2011, indicated the resident's physician would submit orders for oxygen. The policy directed staff to record the use of oxygen in the medical record to indicate flow rate, mode of administration, frequency, duration of use, vital signs, lung sounds and skin conditions as indicated by the resident condition. In addition the resident's response to oxygen. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure there is timely notification to providers of a change of condition. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care	21942		2/14/22

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21942	Continued From page 27 home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to form a family council. Findings include: On 1/21/22, at 11:12 a.m. therapeutic recreation director (TR)-A stated social services had always been in charge of the family council for the 19 years she had worked at the facility. TR-A stated the facility administrator left abruptly in December of 2020, and the family council meeting that was set up did not occur. TR-A stated she was not sure why the meeting did not occur. On 1/21/22, at 11:16 a.m. social services (SS)-A stated she started on 12/23/21, and was not aware that setting up a family council was part of her job. On 1/21/22, at 11:22 a.m. the associate administrator verified a family council had not been established. The associate administrator thought the last family council was in November of 2020. The facility did not have a policy for family council. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could	21942	Corrected	

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21942	Continued From page 28 develop, review, and/or revise policies and procedures to ensure attempts are made annually to establish a family council. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		

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 _____	**01/27/2022**

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

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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. At the time of this survey, The Waterview Woods LLC 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		02/11/2022

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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	245277	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/27/2022**

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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 a 2nd-floor addition constructed in 1965 to the 1961 building. In 1980 a 3-story addition with a basement was built. All buildings are of 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 55 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.6 and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, sections 10.16.3.2 and 14.5.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/27/2022 at 11:00 AM, it was revealed by a review of available documentation from January	K 345	K345 Fire Alarm System – Testing and Maintenance Immediate Corrective Action: Replace annunciator panel as planned on 2/14/22. Recurrence will be prevented by: A statement of work or invoice will be retained to demonstrate compliance. Inspection and testing of the panel will be conducted routinely. Completed date: 2/14/22	2/14/22

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K 345	Continued From page 3 2021 the annunciator panel at the nurse's station is not functional. In a work order from October 2021 from the vendor, a new annunciator has been ordered and is due to be delivered in the near future. An interview with the Facilities Maintenance Director verified this deficient finding at the time of discovery.	K 345	Corrective action will be monitored by: Environmental Services Director, Administrator, and/ or Designee	