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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: X3Q6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00582

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245283**
2.STATE VENDOR OR MEDICAID NO.
(L2) **228663700**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE WATERVIEW PINES LLC**
(L4) **1201 8TH STREET SOUTH**
(L5) **VIRGINIA, MN** (L6) **55792**

4. TYPE OF ACTION: **2** (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 **07/22/2021** (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 **83** (L18)
13.Total Certified Beds **83** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X 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)
__ X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	83			
(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):
The following life safety code waivers were forwarded to the CMS Region V Office for final review and determination: K521, K252
Approval of the waivers was recommended

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE - NE II 09/27/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/21/2021 (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
08/01/1985
(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 (L33)

DETERMINATION APPROVAL

Electronically delivered
August 12, 2021

Administrator
The Waterview Pines LLC
1201 8th Street South
Virginia, MN 55792

RE: CCN: 245283
Cycle Start Date: July 22, 2021

Dear Administrator:

On July 22, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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(ies) 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 September 11, 2021.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 11, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 11, 2021.

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.

This Department is also recommending that CMS impose:

• 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.

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 $11,160; 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.

If you have not achieved substantial compliance by September 11, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Waterview Pines Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 11, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. 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" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 January 22, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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 (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW PINES LLC	**1201 8TH STREET SOUTH VIRGINIA, MN 55792**

(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 7/19/21, through 7/22/21, 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 7/19/21, through 7/22/21, 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 following complaints were found to be UNSUBSTANTIATED: H5283033C (MN74932), H5283034C (MN74805). 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 substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/20/2021

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 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely repositioning was completed to prevent the development and worsening of a pressure ulcer for 1 of 4 residents (R50) reviewed for pressure ulcers. Findings include: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage	F 686	F686 Treatment to Prevent/Treat Pressure Ulcers Immediate Corrective Action: Resident #50 was toileted/repositioned as soon as issue was identified. Skin check was completed with no new concerns noted. NAR assigned to this resident was re-educated on the need to provide these services timely. Corrective Action as it applies to others: The ADL Assist per Care Plan Policy was reviewed and remains current. All nurses, TMAs, and NARs were re-educated on the ADL Assist per Care Plan Policy specifically providing assistance with toileting/repositioning per resident individualized care pan. They will also be educated to notify nurse to document in PCC for any refusals. All residents needing assistance with toileting/repositioning will be provided this	8/27/21

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F 686	Continued From page 2 and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. R50's Transfer/Discharge Report dated 7/22/21, indicated R50's diagnoses included malignant neoplasm of the right breast, secondary malignant neoplasm of bone and rheumatoid arthritis. R50's quarterly Minimum Data Set (MDS) dated 6/24/21, indicated R50 was cognitively intact, exhibited no behaviors or rejection of care. R50's MDS further indicated R50 was assist of one for bed mobility, transfers, toilet use, and personal hygiene. R50's MDS also indicated R50 was incontinent of bladder and was not on a toileting program. R50's MDS indicated R50 was at risk for pressure ulcers, had one Stage 3 pressure ulcer, and one Unstageable pressure ulcer. R50's care plan initiated 3/31/21, indicated R50 was at risk for skin breakdown related to impaired mobility, occasional incontinence, and potential for shearing. R50's care plan further indicated R50 had a pressure ulcer to right the heel and directed staff to fold a blanket under left knee and ankle. R50's care plan indicated R50 was to	F 686	assistance per care plan/care sheet details. Date of Compliance: 8/27/21 Recurrence will be prevented by: Audits of 5 random residents will be completed weekly x 4 then monthly x 2 months to assure timely assistance is provided for toileting and repositioning. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	

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F 686	Continued From page 3	F 686		

wear a small boot on the left foot, and a large boot on the right foot while in recliner chair or while in bed. R50's care plan indicated R50 had a pressure redistribution mattress, and a pressure reduction cushion for wheelchair. R50's care plan further indicated R50 had an alteration in elimination and was occasional incontinent of bowel and bladder. R50's care plan directed staff to offer toileting every two hours and as requested, assess for incontinence, and provide necessary incontinence cares every two hours and as requested.

R50's nursing assistant care guide dated 3/18/21, indicated R50's transferred with assist of one with the use of a ceiling (mechanical) lift, was incontinent of bladder, and directed staff to float heels while in bed and recliner. R50's NA care guide sheet lacked direction on frequency for repositioning and toileting schedule for R50.

R50's quarterly assessment note dated 6/14/21, indicated R50 was at risk for skin breakdown due to decreased mobility, circulatory issues secondary to metastatic cancer, and decreased sensation in lower legs. R50 had an open, healing blister to the right lower inner ankle and a large purple, intact blister to right heel, and an open area to back of left calf.

R50's progress note dated 7/13/21, indicated R50 was seen by physician assistant (PA). PA note indicated R50 pressure injuries to bilateral lower extremities (BLE) were unavoidable due to absence of feeling in legs secondary to cancer diagnosis and limitation with positioning with positioning due to intense back pain. R50 was unable to tolerate laying in bed, sitting in wheelchair, or sitting on recliner alternating

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F 686	Continued From page 4	F 686		

airflow overlay due to intense back pain, and sleeps in her recliner chair. R50 had worked with occupational therapy (OT) on positioning and pressure relief. Several different positioning wedges and cushions had been tried and ended up creating new pressure areas.

On 7/21/21, from 7:13 a.m. through 10:28 a.m. R50 was continuously observed. R50 was not offered repositioning or toileting during that time (3 hours and 15 minutes).

On 7/21/21, at 10:28 a.m. nursing assistant (NA)-G stated R50 would let her know when she needed to use the bathroom or needed her incontinent brief changed. NA-G stated R50 was checked last on the night shift. NA-G stated R50 needed to be turned and repositioned every two hours, and her incontinent brief checked. NA-G stated at 8:10 a.m. NA-G offered repositioning and R50 declined. NA-G stated she reported R50's refusal to reposition to licensed practical nurse (LPN)-C.

On 7/21/21, at 10:42 a.m. LPN-C stated NA-G did not report R50 declined repositioning, and further stated she was unaware R50's had not been repositioned in over three hours.

On 7/21/21 at 10:43 a.m. registered nurse (RN)-D stated R50's care plan directed staff to offer repositioning, toiling and check R50's incontinent brief every two hours. RN-D stated R50 had a history of declining repositioning, and had been educated on the risk vs benefits. RN-D further stated although R50 had a history of refusing, R50 still should be offered repositioning, and the nurse should be notified of any refusals. RN-D was informed continuous observations were

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F 686	Continued From page 5	F 686		

completed on R50, and R50 had not been offered repositioning, toileting or her incontinent brief checked in over three hours. R50's incontinent brief and skin was observed with NA-G and RN-D. RN-D stated R50 had no new pressure ulcers, and did not have worsening of current pressure ulcers.

On 7/21/21, at 01:21 p.m. RN-D stated she measured R50's pressure ulcers weekly. RN-D reviewed R50's pressure ulcer measurements from 7/16/21: her right heel was unstageable and measured 4.5 cm x 3.5 x 1.5 cm and reported it started out as a blister and didn't really know what was going on underneath. RN-D stated R50's left superior calf measured 2.5 cm x 2 cm x 0.2 Stage 3 and left inferior calf measured 2.5 cm x 2 cm x 0.2 cm. RN-D verified R50's left inferior calf was slight bigger in length and width the wound was shallower. RN-D stated R50's pressure ulcer to heels and calf were progress weekly and the wound bed tissues were a good beefy red color and had no slough.

On 7/22/21, at 1:01 p.m. the director of nursing (DON) stated she would expect staff to follow the residents care plan which directed resident cares. The DON stated if a resident refused turning and repositioning it was expected of staff to re-approach the resident, have a different staff member attempt, and if the resident continued to refuse, report the refusal to the nurse. The nurse would approach the resident and provide education on the importance of repositioning. The DON stated three hours of not being repositioned was not unacceptable and put R50 at risk of developing new or worsening pressure ulcers.

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	245283	A. BUILDING _____ B. WING _____	C 07/22/2021

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THE WATERVIEW PINES LLC	1201 8TH STREET SOUTH VIRGINIA, MN 55792

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F 686	Continued From page 6 A facility policy on turning and repositioning was requested and not provided.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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, and document review, the facility failed to ensure supervision of a resident with swallowing difficulties was provided during dining to prevent choking and aspiration for 1 of 3 residents (R58) reviewed for accidents. Findings include: R58's Face Sheet printed 7/22/21, indicated R58's diagnoses included failure to thrive, traumatic brain injury, and dysphagia (difficulty swallowing). R58's quarterly Minimum Data Set (MDS) dated 6/28/21, indicated R58 had a severe cognitive deficit, usually understood others, and required supervision and set-up assistance with eating. R58's care plan initiated 10/14/20, indicated R58 had a pureed consistency diet with honey thick liquids due to dysphagia, preferred to eat in the main dining room, and directed staff to set up,	F 689	F689 Accident Supervision Immediate Corrective Action: Resident #58 will receive feeding assistance per his care plan. Corrective Action as it applies to others: The Policy and Procedure for Dysphagia-Clinical Protocol and ADL Assist per Care Plan policy were reviewed and remain current. All residents will be reviewed to ensure that any resident at risk for aspiration is care planned to have assist at meals. All nurses, TMAs, and NARs will receive education on the need to provide feeding assist per individualized resident care plan. If a resident who requires assistance/supervision with eating refuses	8/27/21

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F 689	Continued From page 7 check on, observe for increased swallowing issues, and provide aspiration precautions. R58's care guide updated 5/6/21, directed R58 was to receive a pureed diet with honey thick liquids, and required set-up assistance and was to be checked on. R58's Speech Therapy (ST) discharge summary dated 2/8/21, indicated it was recommended that R58 receive a puree consistency diet with honey thick liquids, supervision during oral intake, and cues to try to swallow due to coughing and overt signs of aspiration on nectar consistency liquids. R58's Video Fluoroscopic Swallow Evaluation (a test used to look at the ability to swallow safely and effectively) report dated 5/6/21, indicated R58 had a moderate-severe dysphagia and recommendations were made for honey-thick liquids. R58's report recommendations included: -R58 required direct supervision while eating and drinking and could benefit from 1:1 feeding assistance -encourage small bites alternated with small sips -swallow twice per bite and sip -check for oral pocketing and ensure he swallows bite of food or liquid before offering another bite or sip -due to tiring during eating, pace the meal and offer more frequent, small meals throughout the day. R58's Speech Therapy progress note dated 7/15/21, indicated R58 continued on a moderately thick and puree consistency diet, and lacked insight into signs and symptoms of aspiration and dysphagia diagnosis. R58 was able to participate with repetition sand verbal prompts. R58 had a	F 689	to eat in dining room, staff need to sit with resident during meal. Date of Compliance: 8/27/21 Recurrence will be prevented by: Audits of 5 residents with need for supervision/assist with meals will be visually assessed weekly x 4 then monthly x 2 to ensure that they are receiving the assistance per their individualized care plan. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	

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F 689	Continued From page 8	F 689		

decrease in overt signs and symptoms of aspiration, though continued to demonstrate a severe swallow impairment, and required intensive services to improve safety and function. R58 also received aspiration precautions training.

On 7/20/21, at 9:21 a.m. R58 was observed eating breakfast in his room, behind the room dividing curtain. R58 was observed to cough slightly, and clear his airway without difficulty, but no staff were within close proximity to hear R58. R58 had a pureed diet. The name plate outside his room door had a blue dot to indicate R58 required thickened liquids.

On 7/21/21, at 9:48 a.m. R58 was observed to be eating unattended in his room. R58 had eaten his hot cereal and was drinking his thickened liquids. R58's scrambled eggs remained on the plate. No staff were observed to be in the area to monitor or supervise R58 during dining.

On 7/21/21, at 9:55 a.m. staff entered R58's room and removed his meal tray from his room. R58 had eaten his hot cereal.

On 7/22/21, at 10:03 a.m. nursing assistant (NA)-E stated R58 had problems swallowing and was on honey liquids and pureed foods. NA-E stated R58 has not choked, but did cough during meals. NA-E stated R58 was to be eating in the dining room, but if he was in his room, he should have someone with him while eating. NA-E stated they had one staff in the hall during meals to watch him and serve others.

On 7/22/21, at 10:54 a.m. licensed practical nurse (LPN)- B stated R58 usually refused to go to the dining room, and would eat in his room alone.

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F 689	Continued From page 9 LPN-B stated R58 probably shouldn't eat in his room alone, as he was an aspiration and choking risk. LPN-B stated staff would be able to hear him cough, but verified staff would not be able to hear him if he was actually choking. LPN-B verified R58 should not be eating alone in his room. On 7/22/21, at 11:43 a.m. speech language pathologist (SLP)-A verified R58 was on a pureed diet with moderately thick liquids. SLP-A stated R58 was eating in his room when he wanted, but should be assisted by staff, as he did not follow recommendations for small bites and sips. SLP-A stated R58 coughed a lot, and needed constant reminders to take small bites and sips. SLP-A stated when she made a recommendation, she verbally told the staff and the registered nurse manager (RNM) what they needed to do for R58. SLP-A stated R58's video fluoroscopy was very severe, and verified he was at risk for aspiration. On 7/22/21, at 2:21 p.m. the director of nursing (DON) verified staff should provide supervision during meals for R58. The DON also verified R58 was cognitively impaired. The facility policy Dysphagia-Clinical Protocol revised 9/17, directed staff to monitor and report evidence of the resident's progress in eating and drinking and tolerance of restrictions. The policy lacked direction to monitor residents with dysphagia during meals to prevent aspiration and related complications.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		8/27/21

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F 690	Continued From page 10 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure toileting/incontinent care was provided for 1 of 4	F 690	F690 Bowel/Bladder Incontinence Immediate Corrective Action:	

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F 690	Continued From page 11 residents (R50) reviewed for incontinence. Findings include: R50's Transfer/Discharge Report dated 7/22/21, indicated R50's diagnoses included malignant neoplasm of the right breast, secondary malignant neoplasm of bone, and rheumatoid arthritis. R50's quarterly Minimum Data Set (MDS) dated 6/24/21, indicated R50 was cognitively intact. R50's MDS further indicated R50 was assist of one for bed mobility, transfers, toilet use and personal hygiene. R50's MDS also indicated R50 was incontinent of bladder and continent of bowel, and was not on a toileting program. R50's Care Area Assessment (CAA) dated 3/26/21, indicated R50 required extensive assistance from staff for toileting, had impaired mobility and required assistance to get to the bathroom. R50's CAA also indicated staff provided peri-care after incontinent episodes and observed R50's for changes in skin integrity related to incontinence. R50's care plan initiated 3/31/21, indicated R50 had an alteration in elimination, and was occasional incontinent of bowel and bladder. R50's care plan directed staff to offer toileting every two hours and as requested, assess for incontinence, and provide necessary incontinence cares every two hours and as requested. R50's nursing assistant care guide dated 3/18/21, indicated R50's was incontinent of bladder, and could make needs known. The care guide lacked direction for frequency of offering toileting.	F 690	Resident #50 was provided incontinence care as soon as discrepancy was noted. Corrective Action as it applies to others: The Policy and Procedure for ADL Assistance and was reviewed and remains current as it pertains to assistance with toileting. All residents needing assistance with toileting will be provided this assistance per care plan/care sheet details. All nurses/TMAs/NARs will be re-educated on the ADL Assistance per Care Plan Policy. The education will include the need for timely toileting per care plan. Date of Compliance: 8/27/21 Recurrence will be prevented by: Audits of 5 random residents will be completed weekly x 4 then monthly x 2 months to assure that residents are being toileted per care plan. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/ADON/Nurse Managers DON/Nurse Managers/Designee	

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F 690	Continued From page 12	F 690		

R50's Bladder Evaluation dated 6/16/21, indicated R50 was incontinent of bladder, had decreased sensation in the legs and feet. R50's Bladder Evaluation further indicated R50 reported R50 was not aware of the need to urinate and it "just happens." R50's Bladder Evaluation directed staff to assess for incontinence/offer toileting assist every two hours as needed.

On 7/21/21, from 7:13 a.m. through 10:28 a.m. R50 was continuously observed. R50 was not offered or toileted during that time (3 hours and 15 minutes).

On 7/21/21, at 10:28 a.m. nursing assistant (NA)-G stated R50 would let her know when she needed to use the bathroom or needed her incontinent brief changed. NA-G stated R50 was checked last on the night shift. NA-G stated at 8:10 a.m. NA-G offered to reposition and check R50's incontinent brief and R50 declined. NA-G stated she reported R50's refusal to licensed practical nurse (LPN)-C.

On 7/21/21, at 10:42 a.m. LPN-C stated NA-G did not report R50 declined to have her incontinent brief checked or changed, and was unaware R50's incontinent brief had not been checked or changed in over three hours.

On 7/21/21 at 10:43 a.m. registered nurse (RN)-D stated R50's care plan directed staff to offer repositioning, toiling and check R50's incontinent brief every two hours. RN-D stated R50 had a history of declining repositioning and had been educated on the risk vs benefits. RN-D further stated staff should still offer toileting and repositioning at least every two hours. RN-D was

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F 690	Continued From page 13 informed continuous observations were conducted on R50, and R50 had not been offered repositioning, toileting or incontinent brief checked in over three hours. R50's incontinent brief was observed with NA-G and RN-D. RN-D stated R50 was wet with tan colored urine. On 7/21/21, at 10:57 NA-G verified R50 had been incontinent of urine, and R50's incontinent brief was saturated with urine. On 7/22/21, at 1:01 p.m. the director of nursing (DON) stated she would expect the NAs to follow the residents Kardex in Point Click Care (PCC) which reflected and directed R50's care. The DON would expect staff to offer and toilet R50 as directed by the care plan, and further stated over three hours since last checked was unacceptable. The DON stated not offering R50 timely toileting put R50 at risk for skin breakdown and urinary tract infection. The facility policy ADL (Activities of Daily Living) Assistance Per Care Plan revised 5/18, directed staff to check and toilet incontinent residents according to the care plan and peri-care provided in between changes.	F 690		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and	F 732		8/27/21

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F 732	Continued From page 14 unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the required nurse staff posting was posted in a prominent location. This had the potential to affect all 77 residents who resided in the facility. Findings include: On 7/19/21, at 1:03 p.m. the nursing staff posting	F 732	F 732 Posted Nurse Staffing Info Immediate Corrective Action: Nurse Staff Hours Posting was moved to front lobby. Corrective Action as it applies to others: The Staffing/Nursing Hours Positing policy was reviewed and remained current. Administrator was educated on need to keep the Nursing Hours Posting in front	

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F 732	Continued From page 15 was noted to be located on a bulletin board at the end of the hallway in the Waters unit, the furthest away from the facility's main entrance. On 7/22/21, at 10:46 a.m. the nursing staff posting was noted to be located on a bulletin board at the end of the hallway in the Waters unit, the furthest away from the facility's main entrance. On 7/22/21, at 10:55 a.m. an interview was conducted with registered nurse (RN)-B. RN-B stated she was unsure who updated the nursing staff posting, and did not know why it was posted at the end of the Waters unit. On 7/22/21, at 11:00 a.m. an interview was conducted with the director of nursing (DON). The DON stated she was not aware the nurse staff posting was to be displayed in a prominent location. The facility policy Staffing/ Nursing Hours Posting dated 1/14, directed each day a nurse staffing report would be posted in a clear and readable format that is readily accessible to residents and visitors at the front door reception desk.	F 732	lobby as it is readily accessible to the public. Date of Compliance: 8/27/21 Recurrence will be prevented by: Audits of Nursing Hours Posting will be conducted weekly x 4 and then monthly x 2 months to ensure that it is located in the front lobby for access to the public. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator Designee/Designee	
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		8/27/21

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F 755	Continued From page 16 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a system was implemented to ensure the disposition of controlled medications (medications that have a high likelihood of abuse) to prevent diversion. This had the potential to affect all 77 residents residing in the facility. Findings include: On 7/21/21, at 10:03 a.m. on the Waters nursing unit, registered nurse (RN)-B stated the facility did not have medication rooms; everything was in the medication carts. A medication bottle was	F 755	F755 Pharmacy Services/Procedures Immediate Corrective Action: All controlled medications were destroyed utilizing the new facility Med Safe Box. Corrective Action as it applies to others: The Policy for Discarding and Destroying Medications and the Policy for the Med Safe Box remain current. All Licensed Nurses and TMA's will be	

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F 755	Continued From page 17 observed on the counter. RN-B stated the medication bottle was meant for destruction, opened an unlocked cupboard and placed the bottle on a shelf in the cupboard. RN-C identified the cupboard as the pharmacy return cupboard. At 10:15 a.m. the door was locked, and when opened, on a shelf was a locked black plastic file folder. Inside the file folder was a tracking sheet with 31 line items of medications that had been placed in the box awaiting destruction. RN-C stated each nursing unit had a bottle labeled Rx Destroyer (provides pharmaceutical waste disposal solutions with compliance to Drug Enforcement Administration) in which the medications were placed for destruction. RN-C did not know if there was a schedule for medication destruction. -at 10:37 a.m. the Meadows medication room was observed. The cupboard for mediations awaiting pharmacy return was locked, the cupboard contained a locked black plastic file with a tracking sheet with 15 line items. -at 11:10 a.m. the director of nursing (DON) stated the current system for destroying controlled medications was an opportunity for diversion, verifying the medications could be missing for a long time and difficult to track if/when they were noted to be missing. -at 11:19 a.m. three file boxes of medications waiting for destruction were reviewed with the DON. On the Waters unit there were 25 entries on one page with two entries with a line drawn through them. On the second page there were six entries. A medication card with oxycodone (narcotic pain medication) 5 milligrams (mg) 19 pills had not been signed into the box, but had	F 755	educated to notify Nurse Manager or DON when a controlled medication is no longer ordered so that medication can be removed from the narcotic controlled box of the med cart and placed directly into the facility Med Safe Box for destruction. Staff will be notified that the RX destroyer will no longer be used and that the controlled meds need to stay in the med cart and counted until it was removed to be placed directly into the Med Safe after being logged onto the destruction sheet by the appropriate staff members. Date of Compliance: 8/27/21 Recurrence will be prevented by: Audits of the destruction of controlled medications will be completed weekly x 4 weeks then monthly x 2 months to assure the proper procedure is being followed. 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: DON/Nurse Managers/Designee	

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been placed in the box. A card with lorazepam (anxiety medication) 0.5 mg three tablets had not been signed into the box.

The following controlled medications and amounts were stored in the file folders:

-oxycodone 5 mg 13 pills
-oxycodone 5 mg 8 pills
-oxycodone 5 mg 14 pills
-hydrocodone/acetaminophen (narcotic pain medication) 5/325 28 pills
-hydrocodone/acetaminophen 5/325 59 pills
-hydrocodone/acetaminophen 5/325 45 pills
-hydromorphone (narcotic pain medication) 2 mg 20 pills
-hydromorphone 2 mg 23 pills
-morphine suppository (narcotic pain medication administered rectally) 5 mg 9.5 suppositories
-tramadol (narcotic pain medication) 50 mg 25 pills
-hydromorphone 2 mg 7 pills
-oxycodone 2.5 mg 5 pills
-oxycodone 5 mg 20 pills
-oxycodone 5 mg 5 pills
-tramadol 50 mg 15 pills
-oxycodone 5 mg 10 pills
-oxycodone 5 mg 23 pills
-hydrocodone 15 mg 19 pills
-tramadol 50 mg 18 pills
-oxycodone 5 mg 19 pills
-oxycodone 5 mg 20 pills
-tramadol 50 mg 19 pills
-hydromorphone 1 mg 23 pills
-tramadol 50 mg 12 pills
-hydrocodone/acetaminophen 5/325 4 pills
-hydrocodone/acetaminophen 5/325 20 pills
-hydromorphone 2 mg 12 pills
-hydromorphone 1 mg 18 pills

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F 755	Continued From page 19 -hydromorphone 1 mg 27 pills -hydromorphone 1 mg 26 pills -hydromorphone 2 mg 28 pills -fentanyl patch (narcotic pain medication) 75 mg 9 pills 50 mcg 5 patches -fentanyl patch 50 mcg 3 patches -tramadol 50 mg 30 pills -hydrocodone/acetaminophen 5/325 20 pills -methadone 5 mg 21 pills -hydromorphone 2 mg 24 pills -lorazepam (antianxiety medication)0.5 mg 30 pills -lorazepam 0.5 mg 8 pills -lorazepam 0.5 mg 8 pills -lorazepam 0.5 mg 30 pills -lorazepam 0.5 mg 3 pills -lorazepam 0.25 mg 7 pills -lorazepam 0.25 mg 19 pills -lorazepam 0.25 mg 30 pills -lorazepam 0.25 mg 17 pills -lorazepam 0.5 mg 7 pills -pregabalin (antianxiety medication) 75 mg 9 pills -at 12:04 p.m. RN-D was interviewed. RN-D verified the process on the units was to destroy the narcotics when the boxes were full. RN-D verified the controlled substances left in the unit file boxes were an opportunity for diversion. On 7/22/21, at 9:50 a.m. the Rx Destroyer bottle was observed in an unlocked room in a bracket above the sink. -at 10:00 a.m. the consulting pharmacist (CP)-D was interviewed. CP-D verified controlled substances that have been discontinued should be destroyed at soon as possible, but at least monthly. CP-D verified full boxes of controlled substances were an opportunity for diversion.	F 755		

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F 755	Continued From page 20 CP-D stated his recommendation would be to keep the RX Destroyer in a locked cabinet. -at 3:08 p.m. RN-D was interviewed. RN-D verifed the RX destroyer was kept locked in the cabinet with the controlled substances waiting for destruction on the Gardens and Meadows units. The facility policy Discarding and Destroying Medications revised 4/2019, directed all controlled substances would be disposed of in accordance with federal, state and local regulations governing management of controlled substances. The policy directed all unused controlled substances shall be retained in a securely locked area with restricted access until disposed of. The policy did not address how long they could be stored or how they would be accounted for while being stored to ensure there was not an opportunity for diversion.	F 755		
F 758 SS=E	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	F 758		8/27/21

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F 758	Continued From page 21 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 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 target behaviors were identified and monitored, and/or side effects of psychotropic medications were monitored to determine the efficacy of psychotropic medications for 4 of 5 residents (R58, R15, R76,	F 758	F758: Free From Unnecessary Psychotropic Medication/PRN Use Immediate Corrective Action: Target behavior tracking was initiated starting with residents #15, #26, #58, #76. Documentation was completed and care	

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F 758	Continued From page 22 and R26) reviewed for unnecessary medications. Findings include: R58's Face Sheet dated 7/22/21, indicated R58's diagnoses included major depressive disorder, conduct disorders, bipolar disorder, and a history of a traumatic brain injury. R58's quarterly Minimum Data Set (MDS) dated 6/28/21, indicated R58 had a severe cognitive impairment, and had no delirium, psychosis, behaviors or mood symptoms during the assessment period. R58's MDS further indicated R58 had received antipsychotic medication and antidepressant medication during the assessment period. R58's care plan initiated 10/14/20, indicated R58 had a mood and behavior alteration related to major depressive disorder and directed staff to monitor and document mood state and behaviors upon occurrence. R58's care plan directed nursing to monitor for adverse drug reactions related to daily use of psychotropic medications. R58's care plan lacked the identification and monitoring of target behaviors. R58's Order Summary Report dated 7/22/21, indicated R58's medication orders included: -Lamictal (prevent and control seizures and may be used to help prevent the extreme mood swings of bipolar disorder) 200 milligrams (mg) by mouth in the morning related to major depressive disorder, -Seroquel (antipsychotic) 200 mg one tablet by mouth at bedtime related to bipolar disorder and major depressive disorder -sertraline (used to treat major depression and	F 758	plans update accordingly. Side effect monitoring was also put in place for these residents. Social Services department was educated on developing and maintaining a fluid target behavior tracking model. Corrective Action as it applies to others: The Policy for Psychotropic Medication Use was reviewed and remains current. All residents with ordered psychotropic meds will be reviewed and target behavior monitoring and side effect monitoring will be put into place. Social Services department will be leading and educating the other IDT members on how to structure behavior tracking so that residents taking psychotropic meds will be reviewed by the IDT team on a regular schedule. Nurses and NARs will be educated on how to document observed target behaviors into the medical record utilizing POC charting or the TAR. Date of Compliance: 8/27/21 Recurrence will be prevented by: Audits of 5 random residents currently using psychotropic medications will be completed weekly x4, then monthly x2 months to ensure completion of target behavior tracking. The results of these audits will be shared with the facility QAPI committee for additional input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Social Services Director/Administrator/ Social Services Designee	

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panic disorder)100 mg by mouth in the morning related to major depressive disorder

R58's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for July 2021, lacked identification and monitoring of target behaviors related to psychotropic medications. R58's MAR and TAR only included monitoring for orthostatic hypotension (drop in blood pressure) one day monthly, and lacked direction for monitoring of side effects of psychotropic medications.

R58's Follow Up Question Report dated 7/1/21, through 7/22/21, indicated R58 was monitored for behaviors every shift, but lacked identification of target behaviors.

R58's Physician progress notes dated 6/23/21, indicated R58 had a major depressive disorder with a current active episode, and was not to have changes to current medications. R58's progress note lacked identification of target behaviors related to psychotropic medications.

R58's Psychotropic Medication Review dated 6/21/21, indicated R58 received Sertraline and Seroquel for depression, and medication side effect monitoring was in place. R58's medication review lacked identification of target behaviors and indication that target behaviors were monitored.

On 7/22/21, at 10:03 a.m. nursing assistant (NA)-E stated R58 did not hallucinate, though could be delusional about going home.

On 7/22/21, at 10:54 a.m. licensed practical nurse (LPN)-B stated she would document

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anything out of the ordinary for a resident who received psychotropic medications. LPN-B stated because she knew R58, she knew his usual behaviors, and identified his behaviors as anger, swearing and self-transferring. LPN-B verified there were no target behaviors identified for R58, and no side effect monitoring.

On 7/22/21, at 2:21 p.m. the director of nursing (DON) verified nursing should monitor for side effects of psychotropic medications. The DON further verified they would be unable to determine efficacy of psychotropic medications if they were not monitoring target behaviors and side effects.

The facility policy Psychotropic Medication Use dated 7/21, directed psychotropic medications could be considered for resident in which symptoms had been identified and the interdisciplinary team (IDT) would determine psychotropic medications to be beneficial. The policy directed residents would only receive psychotropic medications when necessary to treat specific conditions for which they were indicated and effective. In addition, the IDT and the 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 IDT would identify, evaluate, and document, symptoms that may warrant the use of psychotropic medications. The nursing staff were directed to monitor for and report any side effects and adverse consequences of psychotropic medications to the primary are provider. The policy further directed antipsychotic medications should be used for specific diagnoses and symptoms or behaviors, which did not include agitation or depression, unless severe and

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non-responsive to other therapies and with psychotic features.

R15's Face Sheet dated 7/22/21, indicated R15's diagnoses included major depressive disorder and anxiety disorder.

R15's admission MDS dated 5/7/21, indicated R2 was cognitively intact, had moderate mood symptoms, and received antianxiety, antidepressant and antipsychotic medications during the assessment period.

R15's Order Summary Report dated 7/22/21, indicated R15's medication orders included an order for venlafaxine (antidepressant also known as Effexor) 75 milligrams (mg), directed to give three tablets in the morning for major depressive disorder and Risperdal (antipsychotic) 0.25 mg every morning and at bedtime related to major depressive order. R15's orders for venlafaxine and Risperdal lacked target behaviors or mood symptoms.

R15's care plan initiated 5/1/20, indicated R15 had the potential for alteration in mood and behavior related to anxiety and depression, and received Risperdal and Effexor. The care plan directed nursing to monitor and document mood state and behaviors upon occurrence. R15's care plan also lacked identification of target behaviors or mood symptoms, and monitoring of target behaviors and mood symptoms related to R15's Risperdal and Effexor order.

R15's MAR from 7/1/21, through 7/22/21, indicated R15 received Risperdal and venlafaxine each day. The MAR lacked identification and monitoring of target behaviors or mood symptoms

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related to use of psychotropic medications.

On 7/22/21, at 11:30 a.m. registered nurse (RN)-D verified R15's medical record lacked the target behaviors and mood symptoms.

R76's Admission Record printed 7/22/21, indicated R76's diagnoses included dementia without behavioral disturbance, anxiety disorder and major depressive disorder.

R76's quarterly MDS dated 7/7/21, indicated R76 was cognitively intact and displayed no mood or behavior symptoms. R76's MDS indicated R76 received antianxiety, antidepressant, anticoagulant, diuretic and opioid medication during the assessment period.

R76's care plan dated 4/30/20, lacked identification of R76's target behaviors for antipsychotic and antianxiety medication use.

R76's Physician Medication Orders dated 7/20/21, included buspirone (antianxiety medication) 7.5 mg every day, for anxiety and itching related to anxiety, clonazepam (antianxiety medication) 0.25 mg in the morning and at bedtime to treat anxiety and sertraline (antidepressant medication) 200 mg in the morning to treat a major depressive disorder.

On 7/22/21, at 12:55 p.m. RN-D was interviewed and verified R76's medical record lacked the target behaviors and mood symptoms.

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Failed to ensure target behaviors were identified and monitored, and/or side effects of psychotropic medications were monitored to determine efficacy of psychotropic medications for 5 of 5 residents (R15, R76, R23, R26, and R58) reviewed for unnecessary medications.

R26's Face Sheet dated 7/22/21, indicated R26's diagnoses included dysthymic disorder (chronic form of depression), psychosis, anxiety, major depressive disorder and panic disorder.

R26's admission MDS dated 5/24/21, indicated R26 was cognitively intact, had moderate mood symptoms, and received antianxiety, antidepressant, and antipsychotic medications during the assessment period.

R26's Order Summary Report dated 7/22/21, indicated R26's medication orders included an order for alprazolam 0.5 milligrams (mg), directed to give one tablet as needed for anxiety, bupropion hydrochloride (antidepressant) 300 mg one tablet in the morning for major depressive disorder, and Latuda 60 mg in the morning for psychosis and depression. R15's orders directed monitoring of psychotic and antidepressant medication monitoring for side effects to include sedation, orthostatic hypertension, symptoms of anticholesterol, extra pyramidal. R26's orders lacked for lacked target behaviors or mood symptom monitoring for antipsychotic and antidepressant medications.

R26's care plan initiated 5/18/21, indicated R26 had the potential for alteration in mood and behavior related to depression, psychosis and

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F 758	Continued From page 28 panic disorder. R26's care plan directed nursing to monitor and document mood state and behaviors upon occurrence. R26's care plan also lacked identification of target behaviors or mood symptoms, and monitoring of target behaviors and mood symptoms related to R26's antidepressant and antipsychotic medications. R26's MAR from 7/1/21, through 7/22/21, indicated R26 received Latuda, bupropion hydrochloride, daily and alprazolam as needed. The MAR lacked identification and monitoring of target behaviors or mood symptoms related to use of psychotropic medications. On 7/22/21, at 11:07 a.m. registered nurse (RN)-D verified R26's medical record lacked identification of target behaviors and mood symptoms.	F 758		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		8/27/21

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F 842	Continued From page 29 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 842		

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	245283	A. BUILDING _____ B. WING _____	C 07/22/2021

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THE WATERVIEW PINES LLC	1201 8TH STREET SOUTH VIRGINIA, MN 55792

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F 842	Continued From page 30 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure pharmacy consultant reviews and recommendations were present and readily accessible in the medical records for 5 of 5 residents (R58. R15, R76, R23, and R26) reviewed for unnecessary medications. Findings include: R58's Transfer/Discharge Report printed 7/22/21, indicated R58 was admitted to the facility on 10/14/20, and R58's diagnoses included major depressive disorder, traumatic brain injury, bipolar disorder, and hypertension. R58's medical record lacked evidence of consultant pharmacist reviews and irregularity logs since December 2020. R15's Transfer/Discharge Report printed 7/22/21, indicated R15 was admitted on 6/2/21, and R15's diagnoses included major depressive disorder, anxiety disorders, respiratory failure, congestive heart failure, heart disease, kidney disease, and chronic non pressure ulcers of the legs. R15's medical record lacked evidence of a consultant pharmacist review and irregularity log.	F 842	F842 Resident Records-Identifiable Information Immediate Corrective Action: All pharmacy consultant reviews and recommendations are readily accessible in R58, R15, R76, R23, and R26's medical record. Corrective Action as it applies to others: The regulation remains current that a resident's medical record needs to be thorough and all items readily accessible. DON and Nurse Managers will ensure that pharmacy consultant reviews and recommendations are communicated/given to the medical records personnel so they are readily accessible and are uploaded into the medical record in a timely manner. Date of Compliance: 8/27/21 Recurrence will be prevented by:	

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F 842	Continued From page 31 R76's Transfer/Discharge Report printed 7/22/21, indicated R76 was admitted on 4/23/2020, and R76's diagnoses included dementia without behavioral disturbance, chronic obstructive pulmonary disease (COPD), hypertension, chronic pain, diabetes, anxiety disorder and major depressive disorder. R76's medical record lacked evidence of consultant pharmacist reviews and irregularity logs since December 2020. R23's Transfer/Discharge Report printed 7/22/21, indicated R23 was admitted on 1/13/17, and R23's diagnoses included Alzheimer's disease, cervicalgia (pain in the neck and shoulder), hypertension (high blood pressure), osteoarthritis, dementia, atherosclerotic heart disease (build up of fats, cholesterol, and other substances in and on the artery walls), and chronic pain. R23's medical record lacked evidence of consultant pharmacist reviews and irregularity logs since December 2020. R26's Transfer/Discharge Report printed 7/22/21, indicated R26's diagnoses included congestive heart failure, COPD, migraine, diabetes, psychosis, anxiety disorder, chronic kidney disease, respiratory failure with hypoxia (low oxygen levels), major depressive disorder, and hypertension. R26's medical record lacked evidence of consultant pharmacist reviews and irregularity logs since admission. On 7/21/21, at 3:35 p.m. THE director of nursing	F 842	Audits of 5 residents pharmacy reviews/recommendations will be completed weekly x 4 weeks then monthly x 2 months to ensure that it is readily available for/in the medical record.. 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: DON/Nurse Managers/Designee	

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F 842	Continued From page 32 (DON) stated the pharmacist reviews had not been uploaded into residents' medical records over the past few months. The DON stated she did not have the pharmacist's reviews or recommendations available. The DON stated they were in an office, waiting to be uploaded, and were not accessible. The DON stated the pharmacist had the reviews, gradual dose reductions and monitoring of side effects and target behaviors. The DON stated they had requested them from the pharmacist earlier in the day. The DON verified there were very limited pharmacist reviews in the medical records, with the last being in December of 2020. On 7/22/21, at 2:21 p.m. The DON verified medical records should be current and accessible. The facility did not provide a policy and procedure for maintaining current medical records.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		8/27/21

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F 880	Continued From page 33 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism 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	F 880		

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F 880	Continued From page 34 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 perform hand hygiene between glove changes, and change gloves to prevent cross contamination during incontinent cares for 1 of 2 residents (R53) reviewed for incontinent cares. Findings include: R53's Transfer/Discharge Report dated 7/22/21, indicated R53's diagnoses included hemiplegia (loss of strength or paralysis on one side of the body), hemiparesis (mild or partial weakness or loss of strength on one side of the body), and urge incontinence. R53's quarterly Minimum Data Set (MDS) dated 6/18/21, indicated R53 was cognitively intact, required assistance with toileting cares, and was frequently incontinent of urine. R53's care plan dated 7/12/19, indicated R53 required assistance with bathing, dressing and grooming, and directed staff to assist with dressing and grooming as needed. R53's care plan indicated R53 was incontinent of urine and	F 880	F880 DPOC Handwashing Immediate Corrective Action: NAR responsible for the breach in infection control during surveyor observation was counseled and re-educated with return demonstration competency on the Hand Hygiene Policy. Corrective Action as it applies to others: All residents have the potential to be affected by the deficient practice. The facility QAPI Committee conducted a Root Cause Analysis of the deficient practice and developed a corrective action plan to prevent recurrence. The Policy and Procedure for proper Hand Hygiene was reviewed and remains current with CDC guidelines. All staff to include the DON and Infection Preventionist will receive re-education on the Hand Hygiene Policy and Procedure. The DON, Infection Preventionist, and Designee will conduct return demonstration competencies on proper hand hygiene with all staff and maintain a	

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F 880	Continued From page 35 directed staff to encourage R53 to inform staff when R53 had soiled her clothing, assist with peri-cares, and change as needed. R53's care plan further directed staff to offer assistance with toileting and incontinent cares in the morning, at bedtime, in between meals, and as needed. During observation on 7/21/21, at 8:15 a.m. nursing assistant (NA)-F performed hand hygiene, entered R53's room, donned gloves and assisted R53 out of bed and into the wheelchair. NA-F assisted R53 into the bathroom and removed her incontinent brief. NA-F removed her soiled gloves, and without performing hand hygiene, donned clean gloves. NA-F handed R53 a wet washcloth and R53 washed her face and upper body while sitting on the toilet. NA-F got a clear bag ready and R53 put the dirty washcloth into the plastic bag. NA-F handed R53 a dry towel and R53 dried her upper body then NA-F assisted with upper body dressing. NA-F washed and dried R53's rectal area and buttocks and with the same washcloth and towel washed and dried R53's peri area while wearing the same pair of soiled gloves. Without changing gloves, NA-F assisted R53 with a clean incontinent brief, put the dirty linens in the clear plastic bag, then assisted R53 with lower body dressing. Wearing the same soiled gloves, NA-F held onto the R53 wheelchair handles and assisted R53 out of the bathroom. While R53 was attempting to brush her hair, NA-F put clean garbage bags into the garbage cans, tied up the trash and dirty linen bags, removed her soiled gloves and washed her hands. NA-F started to remove R53's soiled bed linens, stopped the process, donned clean gloves, finished stripping R53's bed, and put soiled bed linens in a clear plastic bag. NA-F removed her soiled gloves, and without	F 880	log with results. Date of Compliance: 8/27/21 Recurrence will be prevented by: The DON, Infection Preventionist and other leadership staff will conduct audits on all shifts, every day for one week to assure proper hand hygiene. The results of the audits will be shared with the facility QAPI Committee and based on the results, the audits will continue daily or decrease in numbers and be discontinued once 100% compliance is demonstrated. Corrections will be monitored by: DON/Designee and Infection Preventionist F880 Infection Control Immediate corrective action: NAR was re-educated on completing appropriate hand hygiene and changing gloves while assisting resident with peri-care. Action as it applies to others: The Handwashing/Hand Hygiene Policy was reviewed and remains current. All nursing assistants and nurses will be re-educated on the Handwashing/Hand Hygiene Policy with regards to	

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F 880	Continued From page 36 performing hand hygiene, handed R53 her eyeglasses. NA-F picked up the bags of dirty linens and garbage, exited R53's room, disposed of dirty lines and garbage in dirty utility room, and washed her hands. On 7/21/21, at 9:27 a.m. NA-F stated during resident cares she would bring in two washcloths and two towels, and further stated one set was used for the upper body and the other set was used for the lower body. NA-F stated she handed R53 a wet washcloth to wash her face and upper body, and NA-F used the second wash cloth to wash her buttocks and peri area. NA-F stated she washed R53's backside, buttocks, then flipped the washcloth over, and washed R53's peri area. NA-F stated she didn't see a problem washing from R53's buttocks and peri area using the same washcloth because NA-F used the opposite sides of the washcloth for each area. NA-F verified gloves and hand hygiene should have completed in between washing R53's bottom and peri area. NA-F further stated gloves should have been changed after providing peri cares before NA-F assisted with dressing and touching R53's wheelchair handles. NA-F stated cleaning from a dirty part of the body to clean part of the body would be a concern for cross contamination. On 7/22/21, at 1:26 p.m. the director of nursing (DON) stated when providing incontinent cares, it was the expectation of staff to wash from clean to dirty, and change gloves in between to prevent cross contamination. The DON further stated anytime gloves were removed, staff were expected to perform hand hygiene to prevent the spread of infection.	F 880	handwashing and changing gloves between peri-care tasks with a focus on washing from clean to dirty areas and changing gloves and handwashing in between these areas. Date of completion: 8/27/21 Recurrence will be prevented by: Visual audits of handwashing/glove changing during ADLs will be conducted 3x weekly for 3 residents on various units x 4 weeks then monthly x 2 months and the results shared with QAPI on the need to increase, decrease, or discontinue the audits. The correction will be monitored by: DON/Nurse Manager/Designee	

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F 880	Continued From page 37 The facility policy Handwashing/Hand Hygiene revised 8/2019, directed the use of alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: -Before and after coming into direct contact with residents; -Before moving from a contaminated body site to a clean body site during resident care; -After contact with a residents intact skin; -After contact with a residents bodily fluids; -After removing gloves.	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an odor free environment for 1 of 1 residents (R53) whose room had a strong odor of urine. Findings include: R53's Transfer/Discharge Report dated 7/22/21, indicated R53's diagnoses included aphasia (a language disorder that affects a person's ability to communicate), hemiplegia (loss of strength or paralysis on one side of the body), hemiparesis (mild or partial weakness or loss of strength on one side of the body), and urge incontinence. R53's quarterly Minimum Data Set (MDS) dated	F 921	F921 Safe/Sanitary/Comfortable Environment Immediate Corrective Action: Resident #53's room was cleaned to remove the urine odor. Care plan was updated to check resident's garbage cans QID for saturated briefs and to remove if found. Care plan was also updated to check resident's room QID for a urine odor and to remove the cause. Administrator and Maintenance should be notified immediately if source is not found so room can be deep cleaned (including floor, inside of garbage cans, and	8/27/21

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F 921	Continued From page 38 6/18/21, indicated R53 was cognitively intact, required assistance with toileting cares, and was frequently incontinent of urine. R53's care plan dated 7/12/19, indicated R53 was incontinent of urine, would urinate on the floor, and tuck soiled clothing in her drawers. R53's goals were to assist R53 with maintaining a clean environment, and directed staff to encourage R53 to inform staff when R53 had soiled her clothing, assist with peri cares, and change as needed. R53's care plan further directed staff to offer assistance with toileting and incontinent cares in the morning, at bedtime, in between meals, and as needed. R53's care plan lacked direction for staff to check and remove incontinent briefs from R53's garbage's. During observation on 7/21/21, at 8:15 a.m. nursing assistant (NA)-F was observed during morning cares for R53. Upon entrance of R53's room, a strong urine odor was noted. After NA-A assisted R53 with morning cares, NA-stripped R53 bed linens and a large wet area was observed from the edge of the mattress to the middle of the mattress. NA-F verified R53's incontinent pad, bed linens, and mattress were saturated with urine. NA-F completed R53's morning cares and removed garbage's from R53's room. On 7/21/21, at 8:40 a.m. housekeeper (H)-B was observed changing R53's garbage's, wiping down R53's pillows and top of mattress. H-B stated the urine odor in R53's room was present daily, and the strength of the urine odor depended on how much R53 was incontinent of urine during the night, and how long R53's incontinent briefs were left in the garbage cans in her room. H-B stated	F 921	mattress) and mattress should be replaced as needed. Corrective Action as it applies to others: The ADL Assistance per Care Plan Policy was reviewed and remains current. All other resident rooms will be checked to ensure that rooms are free from urine odor. All nurses, housekeepers, and NARs will be educated to check resident garbage cans for saturated briefs and to remove if found. Also, educated to have housekeeping deep clean room if any unpleasant odors are present in room and include floor, inside of garbage cans, and mattresses. Administrator and Maintenance should be notified if odor persists so further follow-up can be completed. Date of Compliance: 8/27/21 Recurrence will be prevented by: Audits of 5 resident rooms including resident #53's room will be completed weekly x 4 weeks then monthly x 2 months to ensure that they are free from odors. 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:	

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F 921	Continued From page 39	F 921	Administrator/Maintenance/Designee	

when R53's bed linens were stripped and there was a wet stain on the mattress, H-B knew R53's bed was soiled with urine and needed to be wiped down. H-B stated the blue covering on the mattress could not be removed and washed, and had asked for the mattress to be replaced in the past due to the mattress smelling of urine.

On 7/21/21, at 9:01 a.m. R53's floor was observed wet with a caution sign in the doorway. R53's room continued to have a strong urine odor.

On 7/21/21, at 9:27 a.m. NA-F stated R53's bed linens were often changed daily due urinary incontinence during the night, and her bedding getting soaked with urine. NA-F stated R53's bed linens, and mattress pad were wet with urine when she assisted R53 in getting up that morning. NA-F stated R53 was independent with toileting, and would call for assistance if needing help while in the bathroom. NA-F stated R53's room typically had a urine odor, and further stated staff were unaware if R53's had incontinent briefs in her garbage cans unless R53 asked for assistance. NA-F stated R53's garbages where checked in the morning and at night after personal cares.

On 7/21/21, at 10:12 a.m. H-B stated another area the urine odor was coming from in R53's room was the garbage cans, and further stated R53 could benefit from having her garbage cans switched out and washed to help eliminate urine odor.

On 7/21/21, at 1:35 p.m. registered nurse (RN)-D stated R53 was incontinent of urine and was wanting to be independent with toileting. RN-D

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F 921	Continued From page 40	F 921		

stated R53 recently agreed to start wearing incontinent briefs and prior to, R53 would take her soiled underwear and pants and hide them. RN-D stated interventions to help with the urine odor were moving R53 to a room without carpet, charcoal bags were tried to help eliminate urine odor. RN-D further stated housekeeping would check garbage's daily in the morning and wipe down R53's mattress every other day. RN-D was unsure if the blue mattress cover could be washed or when R53 received a new mattress. RN-D stated staff should be checking R53's garbage's a couple times through their shift. RN-D verified R53's care plan and care guide sheet lacked direction of staff to check R53's garbage's. RN-D stated checking R53's garbage's and removing incontinent briefs would help reduce urine odor.

On 7/22/21, at 8:24 a.m. H-A stated R53's room had an "eye watering urine odor" in her room. H-A stated R53's mattress was wiped down daily if the bedding was stripped, indicating R53's bed linens were soiled of urine. H-A stated R53 would put her heavy urine-soaked briefs in her garbage's and H-A had no idea how long the incontinent briefs were in the garbage. H-A stated R53 could benefit from a new mattress, garbage's checked more frequently during the day, and garbage cans cleaned on a regular basis.

On 7/22/21, at 1:26 p.m. the director of nursing (DON) stated she was aware of the urine odor in R53's room, and had moved R53 to a room without carpet and used charcoal bags in the past. The DON stated if R53's mattress was smelling of urine, staff have been trained and educated if new equipment was need to let her

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	245283	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 921	Continued From page 41 know. The DON agreed checking R53's garbage's for incontinent briefs more frequently and replacing R53's mattress would help reduce the urine odor. A facility policy on housekeeping and environmental was requested and not received. A facility policy ADL (activities of daily living) Assistance Per Care Plan revised 5/18, directed staff remove all soiled linen and clothing immediately from the residents area to prevent odors.	F 921		

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, The Waterview Pines 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code (NFPA 99). THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/22/2021

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

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K 000	Continued From page 1 DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail 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. This facility was inspected as one building. The Waterview Pines is a one-story building constructed in 1967, that was determined to be of Type V(000) construction, because of the presence of combustible wood framing in the ceiling of the upper level. In 1984 a Type II(000) addition was added and in 1997 a Type II(111) addition was added. For the purposes of this	K 000		

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K 000	Continued From page 2 inspection the building was inspected as a Type V(000), which meets the standard. The facility to include the original 1967 building and the two additions have a full basement. The facility is protected throughout by a complete fire sprinkler system. The facility also has smoke detection throughout the corridors and spaces open to the corridors. The facility has a capacity of 83 beds. At the time of the survey the census was 77. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 163 SS=F	Interior Nonbearing Wall Construction CFR(s): NFPA 101 Interior Nonbearing Wall Construction Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 19.1.6.4, 19.1.6.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install non-combustible framing, above the ceiling, in two locations in accordance with the NFPA Life Safety Code 101 2012 edition section 19.1.6.3. This deficient practice could	K 163	K163: Interior Nonbearing Wall Construction – 1. The areas above the ceiling in tub room A and tub room B where limited combustible framing material was	9/3/21

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K 163	Continued From page 3 have a widespread impact on the residents within the facility. Findings include: On 07/21/2021 at 12:15 PM, it was observed that in two areas above the ceiling in tub rooms of "A & B" wings limited combustible framing material has been used. This deficient practice was confirmed by the Regional Maintenance Director.	K 163	corrected by replacing the wood 2x4s with metal studs. 2. All areas above the ceiling where limited combustible framing material may be present were inspected and corrected. 3. The facility will monitor any work in above the ceiling to ensure appropriate non-combustible materials are used. 4. Maintenance Director or Designee 5. Date of compliance: 9/3/2021	
K 252 SS=D	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was revealed that the facility failed to provided proper means of egress from the basement storage area under the "A" wing, in accordance with the NFPA Life Safety Code 101 2012 edition section 19.2.5.5.2. This deficient practice could have an isolated impact on the residents within the facility..	K 252	K252: Number of Exits □ Corridors Waiver submitted.	9/3/21

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K 252	Continued From page 4 Findings include: On 07/21/2021 at 1:05 PM, it was observed that the storage area in the basement, under the "A" wing, only has one exit. This area is approximately 7,290 square feet in size. Rooms over 2,500 square feet require two remote exits. This deficient practice was confirmed by the Regional Maintenance Director.	K 252		
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 test and maintain the fire alarm per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition) National Fire Alarm Code, sections 14.5.3. and 14.6.2.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/21/2021 at 10:51 AM, during a review of all available fire alarm test and inspection	K 345	K345: Fire Alarm System – Testing and Maintenance 1. An inspection of all initiating devices was completed. 2. New forms are currently in use by all contractors which outline and itemize all devices in the system. 3. The facility will audit inspection documentation 2x/year for 2 years to monitor future performance and ensure solutions are sustained. The results of the audits will be shared with the facility QAPI committee for input on the need to	9/3/21

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K 345	Continued From page 5 documentation and an interview with the Regional Maintenance Director, it was revealed that the facility could not provide any current documentation verifying that a semiannual inspection of all initiating devices had been completed. This deficient practice was confirmed by the Regional Maintenance Director.	K 345	increase, decrease or discontinue the audits. 4. Maintenance Director or Designee 5. Date of Compliance: 9/3/2021	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations, a review of available documentation review and staff interview, that the facility has failed to install the facility's heating and ventilation in accordance with the NFPA Life Safety Code 101 2012 edition sections 19.5.2.1 and 9.2.1, and NFPA 90A (2012 edition), Standard for the Installation of Air-Conditioning and Ventilating Systems, section 4.3.12.1.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 19.4.1.1. This deficient condition could have a widespread impact on the residents within the facility.	K 521	K521: HVAC – see waiver request(attachment)	9/3/21

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K 521	Continued From page 6 Findings include: 1. On 07/21/2021 at 12:04, observations revealed that wing A and B have air supplies located in the corridors and the resident rooms have air exhausts located in the bathroom. This combination of air movement indicated that the facility is using these corridors as a return air plenums. 2. On 07/21/2021 at 10:45 AM, during a review of all available fire damper test and inspection documentation and an interview with the Regional Maintenance Director, it was revealed that the facility could not provide any current documentation verifying that the fire and smoke damper test and inspection had been completed since 01/06/2016. These deficient practices were confirmed by the Regional Maintenance Director.	K 521		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced	K 712		9/3/21

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K 712	Continued From page 7 by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2 and 19.7.1.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1) On 07/21/2021, at 10:30 AM., during the review of all available fire drill documentation and interview with the Regional Maintenance Director it was revealed that the facility did not vary the times of the 2nd shift fire drill by conducting 3 of 4 drills in the 4 PM hour. 2) On 07/21/2021, at 10:30 AM., during the review of all available fire drill documentation and interview with the Regional Maintenance Director it was revealed that the facility did not conduct 8 of 12 monthly tests of the DACT during the 1st and 2nd shift fire drills. These deficient conditions were verified by the Regional Maintenance Director.	K 712	K712: Fire Drills 1. Fire drills on the 2nd shift will have varying times by using Monarch's fire drill schedule. The DACT will be tested during fire drills per the fire drill schedule, per policy. 2. The fire drill schedule includes varied times for all shifts and includes a checkbox to ensure the DACT is tested as well. 3. Audits will of fire drills and DACT testing will be conducted monthly for 6 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 audits. 4. Maintenance Director or Designee 5. Date of Compliance: 9/3/2021	