DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 26, 2021

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

RE: CCN: 245277
Cycle Start Date: October 14, 2021

Dear Administrator:

On December 7, 2021, we notified you a remedy was imposed. On December 23, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 15, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 6, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 1, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 6, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 15, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered

December 7, 2021

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

RE: CCN: 245277
Cycle Start Date: October 14, 2021

Dear Administrator:

On November 1, 2021, we informed you that we may impose enforcement remedies.

On November 18, 2021, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby 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:

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 6, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 6, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 6, 2022.

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

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

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 January 6, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Waterview Woods Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 6, 2022. 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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 14, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 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.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	C 11/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 11/16/21, through 11/18/21, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was found to be IN compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/16/21, through 11/18/21, a standard abbreviated survey was conducted at your facility. 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 SUBSTANTIATED: H5277079C (MN58516), with a deficiency cited at (F689). H5277082C (MN73069). H5277088C (MN77860). AND The following complaints were found to be UNSUBSTANTIATED: H5277080C (MN60089). H5277081C (MN61603). H5277083C (MN77575). H5277084C (MN74792). H5277085C (MN74506). H5277086C (MN74106) H5277087C (MN73398).	F 000		

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

Electronically Signed | 12/08/2021

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 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. IN ADDITION: On 11/16/21, through 11/18/21, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.73 Infection Control. The facility was determined to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		12/15/21

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F 689	Continued From page 2 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 comprehensively assess the cause of the fall and interventions to prevent further falls for 1 of 3 residents (R12) reviewed for accidents. Findings include: R12's Admission Record printed 11/18/21, indicated R12's diagnoses included chronic respiratory failure with hypoxia (low oxygen levels), cerebral infarction (stroke) with hemiplegia and hemiparesis (weakness on one side of the body), repeated falls, metabolic encephalopathy (damage or disease that affects the brain, history of traumatic fracture, and osteoporosis (conditions in which the bones become weak and brittle). R12's quarterly Minimum Data Set (MDS) assessment dated 10/11/21, with an assessment reference date of 10/6/21, indicated R12 had a severe cognitive impairment, required extensive assistance with bed mobility, transfers, locomotion, and toilet use, had shortness of breath (SOB) with exertion and when sitting at rest, and had no falls since the previous MDS which was completed 7/21/21. R12's care plan initiated 4/2/21, identified R12 as	F 689	F689: Free of Accidents Hazards/Supervision/Devices Immediate Corrective Action: R2 was reviewed in IDT along with most recent falls to complete an RCA on those falls and care plan updated as appropriate. Action as it Applies to Others: The Policy for Fall Prevention and Management was reviewed and remains current. All resident falls were reviewed in last 30 days and RCA's completed. Care plan was updated to ensure that resident has a comprehensive safety care plan related to falls. DON and nurse management team will be re-educated on need to complete an RCA after each fall and update care plan with appropriate safety interventions. Date of Compliance: 12/15/21 Reoccurrence will be prevented by: Audits on 5 resident falls will be completed to ensure an RCA was completed and interventions were placed on care plan weekly x 4 weeks then monthly x2	

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F 689	Continued From page 3 being at risk for falls related to a history of falls with fractures with a goal that R12 would be safe and free from falls. Interventions to prevent falls included provision of a grabber, a sign in resident room to call for assistance for items out of reach, keep the call light within reach and monitor for safety. R12's care plan directed all staff to review past falls and attempt to determine the cause of falls, record possible root causes, and alter or remove any potential causes if possible. R12's undated nursing assistant slip directed staff that R12 required assist of one for transfers and toileting. R12's Fall Review Evaluation dated 4/2/21, identified R12 as being at risk for falls related to a history of falls and a fall with a cervical spine fracture. R12's fall evaluation included interventions of keeping call light and frequently used items within reach and remind R12 to use her call light. Fall on 8/11/21 R12's progress notes dated 8/11/21, at 4:40 p.m. indicated R12 had a fall from her wheelchair while transferring herself to bed. R12 had red marks on her back from scraping it on the bed railing. R12's medical record lacked indication of a root cause analysis or interventions initiated to prevent further falls. A facility incident report dated 8/11/21, indicated R12 had fallen from her wheelchair while transferring herself into bed. R12's incident report indicated R12's predisposing factor to the fall was confusion, unsteady gait, narcotic use, but lacked a comprehensive root cause analysis of R12's fall.. In addition R12's incident report	F 689	months. 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 689	Continued From page 4	F 689		

and medical record documentation lacked evidence of initiation of new appropriate interventions to prevent further falls.

R12's progress notes dated 8/12/21, indicated R12's Ativan (anti-anxiety medication) had been held per family request, as resident had not done well in the past, and resident was more alert and using her call light appropriately that day.

Fall on 8/14/21
R12's progress notes dated 8/14/21, at 1:50 p.m. indicated R12 had fallen without injury. R12 had attempted to self transfer and lost her balance causing R12 to fall. R12 had a small skin tear to her right upper hand. R12's progress note indicated R12 was noted to have more confusion with a recent change in medication, so the facility notified hospice.

R12's progress notes dated 8/14/21, at 5:37 p.m. indicated R12's Ativan was discontinued due to continued falls.

A facility incident report dated 8/14/21, at 1:50 p.m. indicated R12 had been found lying on the floor in her room due to R12 losing her balance while transferring herself. R12 was confused and was unable to state the reason for her fall. R12's incident report indicated the immediate actions taken included placing R12's call light within reach after transferring R12 into her wheelchair and discontinuation of R12's Ativan. R12's progress notes, and incident report lacked evidence of a comprehensive root cause analysis and follow up of interventions initiated to determine effectiveness.

Fall on 8/24/21

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F 689	Continued From page 5	F 689		

R12's progress notes dated 8/24/21, indicated R12 was found sitting on the floor in front of her wheelchair. R12 was assisted back into her wheelchair.

A facility incident report dated 8/24/21, at 8:00 p.m. indicated R12 was found sitting on the floor in front of her wheelchair, and was assisted back into her wheelchair. R12's incident report indicated the predisposing factor was ambulating or transferring herself without assistance, but lacked a comprehensive assessment of a root-cause analysis. R12's incident report and electronic record lacked evidence of the initiation of interventions to prevent further falls.

R12's progress notes dated 10/6/21, indicated R12 required moderate assistance of one to sit to stand and transfer, and with toilet use. R12 was able to walk short distances in her room and was able to pick up an object, and move about her room independently in her wheelchair.

R12's progress notes dated 10/6/21, indicated R12 had a severe cognitive impairment.

Fall on 10/7/21
R12's progress notes dated 10/7/21, at 12:54 p.m. indicated R12 had fallen off the toilet, and was found sitting on the bare toilet with the seat up and the toilet raiser on the floor next to her. R12 was not wearing socks, and staff encouraged R12 to use the call light if needing assistance and to have gripper socks on her feet when not wearing shoes.

A facility incident report dated 10/7/21, at 12:49 p.m. indicated R12 had fallen off the toilet and

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F 689	Continued From page 6	F 689		

was found sitting on the bare toilet with the seat up and toilet riser was on the floor. R12 stated she had fallen. R12's incident report indicated R12 was responding to toileting needs at the time of her fall. . R12's incident report and EMR lacked evidence of a comprehensive root-cause analysis and initiation of appropriate interventions to prevent further falls.

On 11/16/21, at 2:47, R12 was observed sitting in her wheelchair in her room. R12 stated she had not had any falls for "quite awhile."

On 11/16/21, at 3:06 p.m. R12 independently stood up from her wheelchair and pulled up a pair of pants she had just put on, and then started changing her shirt.

On 11/16/21, at 3:18 p.m. R12 was observed to be changing her pants again. R12 stood up independently, dropped her television remote on the floor, sat down in her wheelchair, and then bent over to pick up the remote without loss of balance.

On 11/17/21, at 11:01 a.m. licensed practical nurse (LPN)-E stated R12 had not had recent falls, used her call light to call for assistance at times, and would transfer herself to the bathroom independently without asking for assistance.

On 11/18/21, at 10:18 a.m. the regional nurse consultant (RNC), verified root-cause analysis should be done to prevent further falls, but had not been done, especially during all the changes in leadership. RNC stated they needed to do that following each fall.

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F 689	Continued From page 7 On 11/18/21, at 4:10 p.m. registered nurse (RN)-C stated they should be doing interdisciplinary team meetings to do a root cause analysis and initiate interventions to prevent further falls. RN-C verified they had not done IDT meetings regarding falls recently, especially during COVID and changes in leadership. The facility policy and procedure for Fall Prevention and Management revised 2/21, directed nursing to complete a Fall Risk Evaluation to identify and document risk factors for falls upon admission, The facility policy and procedure further directed staff to identify interventions related to the specific risk and causes to attempt to prevent the resident from falling and minimize the effects of a fall. The nursing staff were directed to initiate new additional interventions or indicate why the current intervention remained appropriate. In addition the staff were to monitor and document the resident's response to interventions. The facility policy and procedure further directed nursing to assess and evaluate each resident's symptoms following a fall, including orthostatic blood pressure (a blood pressure taken with a change in positions to determine if a resident's blood pressure significantly drops and may be causing dizziness).	F 689		
F 880 SS=E	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	F 880		12/15/21

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	245277	A. BUILDING _____ B. WING _____	C 11/18/2021

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

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F 880	Continued From page 8	F 880		

diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism 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

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F 880	Continued From page 9 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure staff utilized an N-95 respirator and isolation gown as directed by the Centers for Disease Control (CDC) while performing routine outbreak COVID-19 testing on 4 of 4 residents (R18, R19, R20 and R21) and 15 facility staff that were observed during testing. This had the potential to affect all 47 residents who resided in the facility. Findings include: The CDC Interim Guidelines for Collecting and Handling of Clinical Specimens for COVID-19 Testing updated 10/25/21, identified healthcare providers collecting specimens were to maintain proper infection control and use recommended personal protective equipment (PPE), which	F 880	F 880 Infection Prevention and Control Immediate Corrective Action: RN-A and RN-B were educated on the appropriate PPE to be utilized when completing COVID testing. Corrective Action as it applies to others: The CDC Interim Guidelines for Collecting and Handling of Clinical Specimens for COVID-19 testing were reviewed and remain current. All staff that perform COVID testing will be re-educated on what PPE is required when completing this activity. Date of Compliance: 12/15/21	

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F 880	Continued From page 10 includes an N95 or higher-level respirator (or face mask if a respirator is not available), eye protection, gloves, and a gown. R18's annual Minimum Data Set (MDS) dated 8/10/21, identified R18 required assistance with all activities of daily living (ADL's) and diagnoses included congestive heart failure (CHF), myocardial infarction (heart attack), and mitral valve insufficiency. R19's quarterly MDS dated 9/2/21, identified R19 required assistance with all ADL's except eating. R19's diagnoses included chronic obstructive pulmonary disease (COPD), pneumonia, and age related physical debility. R20's annual MDS dated 8/23/21, identified R20 was totally dependent with transfers and required assistance with all other ADL's except eating. R20's diagnoses included type 2 Diabetes Mellitus (DM), and adult failure to thrive. R21's annual MDS dated 9/13/21, identified R21 was wheelchair bound and required assistance will all ADL's. R21's diagnoses included type 2 DM, and hypothyroidism. During observation of routine polymerase chain reaction (PCR) testing of residents for COVID-19 on 11/17/21, at 10:36 a.m. registered nurse (RN)-A tested four residents (R18, R19, R20, R21) while wearing one surgical face mask, facility-assigned eye goggles, and gloves. RN-A did not wear an N-95 respirator or an isolation gown while testing residents. During observation on 11/18/21, at 9:44 a.m. through 11:19 a.m. RN-A was performing routine	F 880	Reoccurrence will be prevented by: Audits on testing of 5 residents/staff will be completed to ensure required PPE is being utilized weekly x 4 weeks then monthly x2 months. 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 See attachments for items for DPOC	

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F 880	Continued From page 11	F 880		

PCR testing on facility staff. RN-A was wearing one surgical face mask, facility-assigned eye goggles and gloves. RN-A was not wearing an N-95 respirator or an isolation gown while testing 13 staff.

On 11/18/21, at 10:15 a.m. RN-B tested facility staff while wearing one surgical face mask, facility-assigned eye goggles, and gloves. RN-B was not wearing an N-95 respirator or an isolation gown. RN-B tested two staff.

During interview on 11/18/21, at 12:32 p.m. RN-A stated her usual practice for testing residents and staff was to wear a surgical face mask, facility-assigned eye goggles and gloves. RN-A would wear an N-95 respirator, isolation gown, facility-assigned eye protection, and gloves if the resident was in quarantine or if the resident had COVID-19 symptoms.

On 11/18/21, at 1:40 p.m. RN-B stated she had worn a surgical face mask, eye goggles and gloves during staff PCR testing. RN-B stated she always wore a surgical mask and would only wear an N95 respirator if the resident had symptoms of COVID-19. RN-B stated she would expect the leadership team to update floor staff on any changes or updates. RN-B stated she was considered floor staff.

On 11/18/21, at 12:41 p.m. the director of nursing (DON) verified she would expect staff to follow the facility's corporate policy for COVID-19 testing, which follows the Minnesota Department of Health (MDH) guidelines.

On 11/18/21, at 12:58 p.m. RN-A stated she and RN-B had been fit tested for N95 respirators.

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F 880	Continued From page 12 RN-A also stated the facility was in conservation mode and had not been re-using masks at the time. The facilities PPE and Hand Hygiene for Point Prevalence Survey (PPS) dated 6/24/2020, identified the swabber involved in specimen collection was to wear a N95 respirator or medical-grade face mask (if respirator not available), face shield, gown, and gloves during specimen collection. The facilities Coronavirus (COVID-19) policy revised 8/20/21, identified COVID-19 as a respiratory illness that could spread from person to person through respiratory droplets expelled with coughing and sneezing, between people within close contact (within six feet), and by touching contaminated surfaces or objects and then touching the mouth, nose or eyes. The Facility Outbreak Protocol directs staff to initiate outbreak and enhanced testing protocols as outlined within the COVID-19 testing policy. The facilities COVID-19 Testing Policy revised 10/5/21, identifies facility staff and residents were to complete outbreak testing per CDC recommendations.	F 880		

Electronically delivered
December 7, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: ZKW111

Dear Administrator:

The above facility was surveyed on November 16, 2021 through November 18, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/16/21, through 11/18/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000		

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2 000	Continued From page 1 when they will be completed. The following complaints were found to be SUBSTANTIATED: H5277079C (MN58516) with a licensing order issued at (S0830). H5277082C (MN73069). H5277088C (MN77860). The following complaints were found to be UNSUBSTANTIATED: H5277080C (MN60089). H5277081C (MN61603). H5277083C (MN77575). H5277084C (MN74792). H5277085C (MN74506). H5277086C (MN74106) H5277087C (MN73398). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulatio	2 000		

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2 000	Continued From page 2 n/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		12/15/21

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2 830	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess the cause of the fall and interventions to prevent further falls for 1 of 3 residents (R12) reviewed for accidents. Findings include: R12's Admission Record printed 11/18/21, indicated R12's diagnoses included chronic respiratory failure with hypoxia (low oxygen levels), cerebral infarction (stroke) with hemiplegia and hemiparesis (weakness on one side of the body), repeated falls, metabolic encephalopathy (damage or disease that affects the brain, history of traumatic fracture, and osteoporosis (conditions in which the bones become weak and brittle). R12's quarterly Minimum Data Set (MDS) assessment dated 10/11/21, with an assessment reference date of 10/6/21, indicated R12 had a severe cognitive impairment, required extensive assistance with bed mobility, transfers, locomotion, and toilet use, had shortness of breath (SOB) with exertion and when sitting at rest, and had no falls since the previous MDS which was completed 7/21/21. R12's care plan initiated 4/2/21, identified R12 as being at risk for falls related to a history of falls with fractures with a goal that R12 would be safe and free from falls. Interventions to prevent falls included provision of a grabber, a sign in resident room to call for assistance for items out of reach, keep the call light within reach and monitor for safety. R12's care plan directed all staff to review past falls and attempt to determine the cause of	2 830	CORRECTED	

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2 830	Continued From page 4 falls, record possible root causes, and alter or remove any potential causes if possible. R12's undated nursing assistant slip directed staff that R12 required assist of one for transfers and toileting. R12's Fall Review Evaluation dated 4/2/21, identified R12 as being at risk for falls related to a history of falls and a fall with a cervical spine fracture. R12's fall evaluation included interventions of keeping call light and frequently used items within reach and remind R12 to use her call light. Fall on 8/11/21 R12's progress notes dated 8/11/21, at 4:40 p.m. indicated R12 had a fall from her wheelchair while transferring herself to bed. R12 had red marks on her back from scraping it on the bed railing. R12's medical record lacked indication of a root cause analysis or interventions initiated to prevent further falls. A facility incident report dated 8/11/21, indicated R12 had fallen from her wheelchair while transferring herself into bed. R12's incident report indicated R12's predisposing factor to the fall was confusion, unsteady gait, narcotic use, but lacked a comprehensive root cause analysis of R12's fall.. In addition R12's incident report and medical record documentation lacked evidence of initiation of new appropriate interventions to prevent further falls. R12's progress notes dated 8/12/21, indicated R12's Ativan (anti-anxiety medication) had been held per family request, as resident had not done well in the past, and resident was more alert and using her call light appropriately that day.	2 830		

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2 830	Continued From page 5 Fall on 8/14/21 R12's progress notes dated 8/14/21, at 1:50 p.m. indicated R12 had fallen without injury. R12 had attempted to self transfer and lost her balance causing R12 to fall. R12 had a small skin tear to her right upper hand. R12's progress note indicated R12 was noted to have more confusion with a recent change in medication, so the facility notified hospice. R12's progress notes dated 8/14/21, at 5:37 p.m. indicated R12's Ativan was discontinued due to continued falls. A facility incident report dated 8/14/21, at 1:50 p.m. indicated R12 had been found lying on the floor in her room due to R12 losing her balance while transferring herself. R12 was confused and was unable to state the reason for her fall. R12's incident report indicated the immediate actions taken included placing R12's call light within reach after transferring R12 into her wheelchair and discontinuation of R12's Ativan. R12's progress notes, and incident report lacked evidence of a comprehensive root cause analysis and follow up of interventions initiated to determine effectiveness. Fall on 8/24/21 R12's progress notes dated 8/24/21, indicated R12 was found sitting on the floor in front of her wheelchair. R12 was assisted back into her wheelchair. A facility incident report dated 8/24/21, at 8:00 p.m. indicated R12 was found sitting on the floor in front of her wheelchair, and was assisted back into her wheelchair. R12's incident report indicated the predisposing factor was ambulating	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00583	A. BUILDING: _____ B. WING _____	C 11/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6	2 830		

or transferring herself without assistance, but lacked a comprehensive assessment of a root-cause analysis. R12's incident report and electronic record lacked evidence of the initiation of interventions to prevent further falls.

R12's progress notes dated 10/6/21, indicated R12 required moderate assistance of one to sit to stand and transfer, and with toilet use. R12 was able to walk short distances in her room and was able to pick up an object, and move about her room independently in her wheelchair.

R12's progress notes dated 10/6/21, indicated R12 had a severe cognitive impairment.

Fall on 10/7/21
R12's progress notes dated 10/7/21, at 12:54 p.m. indicated R12 had fallen off the toilet, and was found sitting on the bare toilet with the seat up and the toilet raiser on the floor next to her. R12 was not wearing socks, and staff encouraged R12 to use the call light if needing assistance and to have gripper socks on her feet when not wearing shoes.

A facility incident report dated 10/7/21, at 12:49 p.m. indicated R12 had fallen off the toilet and was found sitting on the bare toilet with the seat up and toilet riser was on the floor. R12 stated she had fallen. R12's incident report indicated R12 was responding to toileting needs at the time of her fall. . R12's incident report and EMR lacked evidence of a comprehensive root-cause analysis and initiation of appropriate interventions to prevent further falls.

On 11/16/21, at 2:47, R12 was observed sitting in

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2 830	Continued From page 7 her wheelchair in her room. R12 stated she had not had any falls for "quite awhile." On 11/16/21, at 3:06 p.m. R12 independently stood up from her wheelchair and pulled up a pair of pants she had just put on, and then started changing her shirt. On 11/16/21, at 3:18 p.m. R12 was observed to be changing her pants again. R12 stood up independently, dropped her television remote on the floor, sat down in her wheelchair, and then bent over to pick up the remote without loss of balance. On 11/17/21, at 11:01 a.m. licensed practical nurse (LPN)-E stated R12 had not had recent falls, used her call light to call for assistance at times, and would transfer herself to the bathroom independently without asking for assistance. On 11/18/21, at 10:18 a.m. the regional nurse consultant (RNC), verified root-cause analysis should be done to prevent further falls, but had not been done, especially during all the changes in leadership. RNC stated they needed to do that following each fall. On 11/18/21, at 4:10 p.m. registered nurse (RN)-C stated they should be doing interdisciplinary team meetings to do a root cause analysis and initiate interventions to prevent further falls. RN-C verified they had not done IDT meetings regarding falls recently, especially during COVID and changes in leadership. The facility policy and procedure for Fall Prevention and Management revised 2/21, directed nursing to complete a Fall Risk Evaluation to identify and document risk factors	2 830		

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2 830	Continued From page 8 for falls upon admission, The facility policy and procedure further directed staff to identify interventions related to the specific risk and causes to attempt to prevent the resident from falling and minimize the effects of a fall. The nursing staff were directed to initiate new additional interventions or indicate why the current intervention remained appropriate. In addition the staff were to monitor and document the resident's response to interventions. The facility policy and procedure further directed nursing to assess and evaluate each resident's symptoms following a fall, including orthostatic blood pressure (a blood pressure taken with a change in positions to determine if a resident's blood pressure significantly drops and may be causing dizziness). SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure a root cause analysis is completed to prevent further falls. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		