

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 18, 2020

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

RE: CCN: 245277

Cycle Start Date: August 18, 2020

Dear Administrator:

On November 9, 2020, we notified you a remedy was imposed. On December 8, 2020 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 November 9, 2020.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective September 24, 2020 be discontinued as of November 9, 2020. (42 CFR 488.417 (b))

However, as we notified you in our letter of September 9, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 18, 2020. 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

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 24, 2020

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

RE: CCN: 245277

Cycle Start Date: August 18, 2020

Dear Administrator:

On September 9, 2020, we informed you of imposed enforcement remedies.

On September 11, 2020, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be 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 attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 24, 2020, will remain in effect.
- Directed plan of correction, Federal regulations at 42 CFR § 488.424 Please see electronically attached documents for the DPOC.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 24, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 24, 2020.

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

The Waterview Woods Llc September 24, 2020 Page 2 admissions.

As we notified you in our letter of September 9, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 18, 2020.

### ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

#### **DEPARTMENT CONTACT**

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

Teresa Ament, Unit Supervisor Duluth Survey Team 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

Phone: (218) 302-6151

#### 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 November 18, 2020 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

#### **APPEAL RIGHTS**

If you disagree with this action imposed on your facility, you or your legal representative may request a

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

### Tamika.Brown@cms.hhs.gov

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

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

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

### INFORMAL DISPUTE RESOLUTION/INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm">https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</a>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html

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

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

PRINTED: 10/30/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245277	B. WING _			C <b>11/2020</b>
	PROVIDER OR SUPPLIER	С		STREET ADDRESS, CITY, STATE, ZIP CODE  601 GRANT AVENUE  EVELETH, MN 55734	1 03/	11/2020
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E 000	was conducted 9/10 facility by the Minne determine compliar Preparedness regulacility was in full considerable because you are ensignature is not requipage of the CMS-25	nrolled in ePOC, your uired at the bottom of the first 567 form.	E 00	0		
F 000	required that the far the electronic documents of 10/20, through survey and a COVI Control survey was the Minnesota Depair your facility was in requirements of 42 Requirements for Laurvey identified the compliance.  The following computation of the facility's plan of as your allegation of Department's accepenrolled in ePOC, yet and the control of the compliance.	h 9/11/20, an abbreviated D-19 Focused Infection conducted at your facility by artment of Health to determine a compliance with CFR Part 483, Subpart B, and ong Term Care Facilities. The e facility was NOT in correction (POC) will serve a from the otance. Because you are your signature is not required	F 00			
ABODATON	form. Your electron be used as verificat	first page of the CMS-2567 ic submission of the POC will ion of compliance.	MATHE	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

**Electronically Signed** 

10/03/2020

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

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,		C (X3) DATE SURVEY	
		245277	B. WING		09/11/2020
	PROVIDER OR SUPPLIER	С		STREET ADDRESS, CITY, STATE, ZIP CODE 601 GRANT AVENUE EVELETH, MN 55734	
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F 000	Continued From pa		F 000		
	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with ostomy Care and Suctioning	F 69	5	10/14/20
	The facility must en needs respiratory of care and tracheal scare, consistent with practice, the comproare plan, the reside and 483.65 of this scare. This REQUIREMENT by:  Based on interview facility failed to ensproperly attached to of 3 residents (R1)  Findings include:  R1's Admission Recall's diagnoses include and chronic respirate deprived of oxygen  R1's admission Mir 7/15/20, identified for MDS further indicate therapy.	and tracheal suctioning. Issure that a resident who are, including tracheostomy uctioning, is provided such h professional standards of ehensive person-centered ents' goals and preferences, subpart. NT is not met as evidenced a and document review, the ure a humidification bottle was be an oxygen concentrator for 1 reviewed for oxygen.  Cord dated 9/11/20, indicated uded acute (sudden onset) tory failure with hypoxia (body		F 695 Respiratory/Tracheostomy Care and Suctioning Immediate Corrective Action: R1 was discharged on 8/29/20. Corrective Action as it applies to others The Policy for Oxygen Administration w reviewed and remains current. All residents who utilize continuous oxygen with bubbler will be assessed to ensure that bubbler is intact with concentrator and patent. All nurses will be re-educated on Oxygen administration. Date of Compliance: 10/14/20 Recurrence will be prevented by: Audits will begin on all residents who utilize oxygen with a bubbler will occur 5x/week x 4 weeks, 3x/week x 2 weeks	: las
	R1's admission Mir 7/15/20, identified F MDS further indicat therapy.	nimum Data Set (MDS) dated R1 had intact cognition. R1's red he received oxygen		All nurses will be re-educated on Oxyge administration.  Date of Compliance: 10/14/20  Recurrence will be prevented by:  Audits will begin on all residents who utilize oxygen with a bubbler will occur	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
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F 695	indicated R1 was oper minute (LPM) was oper minute (LPM) was an alteration in oxygrespiratory failure a directed staff to administration in oxygrespiratory failure a directed staff to administration of the indicated R1's physicated R1's physican order treatments. R1 requants left in his room problem with his oxygen was changed to On 9/10/20, at 1:00 conducted with famishe received a call R1. F-A stated R1 in heard R1 say, "I'm happened." F-A stated R1 in heard R1 say, "I'm happened." F-A stated R1 in heard R1 say, "I'm happened." F-A stated R1 told her in stated she overheathim to a portable or was told by a facility incident, a humidiffuscrewed on the oxygen of the received oxygen.	ridered oxygen at nine liters with use of a nasal cannula.  Ilved 7/22/20, indicated R1 had gen/gas exchange related to nd hypoxia. The care plan minister oxygen as ordered.  dated 7/29/20, at 10:11 a.m. ician was notified R1 had saturations (measurement of stream) during the morning. Fred scheduled nebulizer uested to have an oxygen in the event there was a ygen concentrator.  dated 8/4/20, indicated R1's work" one day of the week, aturation fell below 60% until a reserve oxygen tank.  p.m., an interview was illy member (F)-A. F-A stated on 7/29/20, at 6:30 a.m. from had left a voicemail and she dying" and "I don't know what ated she called R1 initiates after she received the nswered the phone. F-A rd staff say they connected cygen tank. F-A stated she y staff-person after the cation bottle was not properly igen concentrator, and R1 had	F 6	95	and 2x/week x 1 week to ensure the oxygen system is patent and function Audit results will be shared with the QAPI committee for input on the neincrease, decrease or discontinue audits.	ioning. e facility eed to	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	· /	(X3) DATE SURVEY COMPLETED	
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F 695	conducted with lice LPN-A stated R1 w with his oxygen durhad called F-A abo  On 9/10/20, at 1:57 conducted with LPI called to R1's room R1's toes were disclooked at R1's toes discolored, however change from R1's restated she then existaff informed her Ediscolored a few morentered R1's room saturation. LPN-B was in the 80's (no stated she then call asked if R1 needed LPN-B stated the comon way" R1's oxygun LPN-B stated she to R1's oxygen tubing LPN-B stated R1 composed saturation. LPN-B stated she to make the stated she to make the stated she to make the stated R1's oxygen tubing LPN-B stated R1 conducted with the The DON stated Normal for the real portable oxygen to make the stated R1's feet turn abnormal for the real portable oxygen to the stated R1's feet turn abnormal for the real portable oxygen to the stated R1's feet turn abnormal for the real portable oxygen to the stated R1's feet turn abnormal for the real portable oxygen to the stated R1's feet turn abnormal for the real portable oxygen to the stated R1's feet turn abnormal for the real portable oxygen to the stated R1's feet turn abnormal for the real portable oxygen to the stated R1's feet turn abnormal for the real portable oxygen to the stated R1's feet turn abnormal for the real portable oxygen to the stated R1's feet turn abnormal for the real portable oxygen to the stated R1's feet turn abnormal for the real portable oxygen to the stated R1's feet turn abnormal for the real portable oxygen to the stated R1's feet turn abnormal for the real portable oxygen to the stated R1's feet turn abnormal for the real portable oxygen tubing the stated R1's feet turn abnormal for the real portable oxygen tubing the stated R1's feet turn abnormal for the real portable oxygen tubing the stated R1's feet turn abnormal for the real portable oxygen tubing the stated R1's feet turn abnormal for the real portable oxygen tubing the stated R1's feet turn abnormal for the real portable oxygen tubing the stated R1's feet turn abnormal for the real portable oxygen tubin	rinsed practical nurse (LPN-A). Tas concerned about an issue ring the day on 7/29/20, and he ut it.  7 p.m. an interview was N-B. LPN-B stated she was non 7/29/20, as staff reported colored. LPN-B stated she and confirmed they were er, verbalized this was not a normal condition. LPN-B ted R1's room. LPN-B stated R1's room. LPN-B stated R1's toes became increasingly inutes later. LPN-B stated she m and obtained an oxygen stated R1's oxygen saturation rmal is 90-100%). LPN-B led the on-call nurse and d to be sent to the hospital. On-call nurse told her there was seen saturation was that low. The instructed staff to connect to a portable oxygen tank. The alled F-A during the incident to N-B stated nursing assistant her a humidification bottle was prectly" when she changed	F 69	5			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, 601 GRANT AVENUE EVELETH, MN 55734	· · · · · · · · · · · · · · · · · · ·	11/2020
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F 695	humidification bottle screwed on the oxy confirmed no other DON stated NAs' h competency evaluated was unsure if a valicompleted with NAcompleted. The DO conduct a mandated unable due to COV On 9/11/20, at 11:14 conducted with NAR1's room at approand noticed R1's fir blue. NA-A stated wasn't getting air. I phone with F-A durinotified the nurse a oxygen concentrate and recovered with stated NA-B change R1's oxygen conceconfirmed she iden was not correctly seconcentrator and oxygen concentrator and oxygen the Occupational H responsible for arrastaff regarding policoxygen therapy included.	e was found to be incorrectly agen concentrator. The DON staff were educated. The ad oxygen therapy ations completed, however, dation competency was after verbal education was DN stated the facility wanted to ry staff meeting, however, was ID-19.  4 a.m. an interview was A. NA-A stated she entered ximately 6:25 a.m. on 7/29/20, agers, toes, and nose were R1 told her he felt like he NA-A stated R1 was on the ang this time. NA-A stated she and R1 was switched from the port of a portable oxygen tank, and a couple of minutes. NA-A and a humidification bottle on trator during nightshift. NA-A tified the humidification bottle or exygen leaked out.  Asygen General Guidelines of The Director of Nursing and ealth Director shall be anging the education of nursing cies and procedures covering uding administration, deffectiveness, precautions,	F 6	95		
F 880 SS=F	Infection Prevention		F 8	880		10/14/20

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C		
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F 880	CFR(s): 483.80(a)( §483.80 Infection C The facility must es infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program. The facility must es and control program a minimum, the foll §483.80(a)(1) A sys reporting, investiga and communicable staff, volunteers, vis providing services of arrangement based conducted accordin accepted national s §483.80(a)(2) Writt procedures for the but are not limited t (i) A system of surv possible communic infections before th persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tr to be followed to pre-	control tablish and maintain an and control program a safe, sanitary and ment and to help prevent the tansmission of communicable tions.  In prevention and control tablish an infection prevention in (IPCP) that must include, at owing elements:  Item for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessmenting to §483.70(e) and following standards;  en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other	F 88	30			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
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F 880	resident; including (A) The type and depending upon to involved, and (B) A requirement least restrictive position of the circumstances. (v) The circumstances or infected contact with residual contact will transmost (vi) The hand hygical by staff involved in §483.80(a)(4) A sidentified under the corrective actions §483.80(e) Linear Personnel must have transport linear sinfection.  §483.80(f) Annual The facility will confect and update This REQUIREM by:  Based on observative review, the facility ensure social distance for 2 contaminated sur assistance for 2 content and the contaminated sur assistance for active the form of the contaminated sur assistance for active the form of the contaminated for active the form of the contaminated sur assistance for active the form of the contaminated sur assistance for active the form of the contaminated sur assistance for active the form of the contaminated sur assistance for active the form of the contaminated sur assistance for active the contaminated surface the contaminated surfa	g but not limited to: duration of the isolation, he infectious agent or organism  I that the isolation should be the bessible for the resident under the nces under which the facility bloyees with a communicable and skin lesions from direct ents or their food, if direct nit the disease; and ene procedures to be followed in direct resident contact.  Tystem for recording incidents he facility's IPCP and the taken by the facility.  S. andle, store, process, and o as to prevent the spread of	F8	F 880 Infection Prevention Immediate Corrective Actio All residents will be assisted rooms. NARs involved were need to sanitize hands in both residents and when coming with surfaces other than the for eating. Kitchen staff me educated on need to wear wask, and washing hands	n: d to eat in their e educated on etween feeding g in contact e utensils used mber was eye protection,	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		LE CONSTRUCTION		E SURVEY PLETED
		245277	B. WING				C <b>11/2020</b>
NAME OF F	PROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	11/2020
					601 GRANT AVENUE		
THE WAT	TERVIEW WOODS LL	С					
					EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 7	F 8	80			
F 880	were wearing prope equipment (PPE) to COVID-19 according Control (CDC) guid the potential to affer in the facility.  Findings include:  COMMUNAL DINING R7's quarterly Mining 8/10/20, identified Fimpairment and receating.  R7's care plan date risk for COVID-19, maintaining social of the second se	or personal protective or prevent the spread of ag to Centers for Disease elines. These practices had ct all 57 residents who resided of all 57 residents who residents are distance of a severe cognitive puired limited assistance of all 57 was at and was non-compliant distancing with other residents. The distancing with other residents.  a.m. an interview was administrator. The difference of the facility was conducting flue to four newly confirmed of the facility. The administrator of cases were identified on the	F8	880	mask or other surfaces prior to pre food.  Corrective Action as it applies to ot The Coronavirus Policy, Handwashing/Hand Hygiene Policy Infection Prevention and Control Prevention Prevention and Control Prevention and remain of All resident trays will be brought to resident rooms and any residents to need assistance will be assisted with eating in their rooms. Room tray set for each nursing wing will be stagged All NARs, Activity Aids (with NAR certification), and nurses will receive education on need to sanitize hand between feeding residents and who coming in contact with surfaces of the utensils used for eating. All kitchen staff will receive education education on handwashing/sanitizin hands after touching face masks. Date of Compliance: 10/14/20 Recurrence will be prevented by: Audits will be completed to ensure resident meal trays are being deliver rooms and that residents that need assistance with eating are receiving assistance with eating are receiving assistance in their room. Audits will be completed to ensure that staff a sanitizing hands in between feeding residents and when coming in contwith surfaces other than the utensil for eating. These audits will occur	hers:  y, and rogram urrent.  hat th ervice ered.  re s in en er than on on ce ceive ng all ered to g this I also re g act	
	observed in the sec	a.m. four residents were cond floor dining room. R7 yed seated next to each other			5x/week x 4 weeks, 3x/week x 2 wand 2x/week x 1 week to ensure compliance.  Audits will be completed to ensure		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245277	B. WING			09/1	; 1/2020
	PROVIDER OR SUPPLIEF			6	TREET ADDRESS, CITY, STATE, ZIP CODE  01 GRANT AVENUE  EVELETH, MN 55734	00/1	1/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 880	at a rounded table of them, and were other. No staff we room.  On 9/11/20, at 9:0 conducted with reconfirmed no staff floor dining room, were approximate RN-A stated resid second floor dining RN-A stated resid room as the facility stated COVID-19 second floor on 9/in the facility. RN-awaiting COVID-1 resided on the second lity was  On 9/11/20, at 9:5 conducted with lic LPN-C stated app the second floor of facility did not stagate in the dining roconfirmed the faci feet social distance all residents who aroom required supeating. LPC-C stadining room, and each table.  On 9/11/20, at 9:5	within arm's reach of each within arm's reach of each are present or near the dining as a.m. an interview was gistered nurse (RN)-A. RN-A are were present in the second and she estimated R7 and R8 by two and one-half feet apart. The ents who were eating in the groom required prompting. The ents were eating in the dining y had staffing issues. RN-A testing was completed on the 10/20, due to confirmed cases and stated the facility was 9 results for residents who cond floor. RN-A stated "a ts also still needed to be tested awaiting consent.  3 a.m. an interview was ensed practical nurse (LPN)-C. roximately 15 residents ate in ining room. LPN-C stated the ager meals, and all residents from at the same time. LPN-C lity was unable to maintain six ing during meals. LPN-C stated ate in the second floor dining pervision or needed assistance ated there were five tables in the three residents were placed at	F 8	380	kitchen staff are wearing eye protection and face mask at all times and are washing/sanitizing hands after touchin face mask. These audits will occur 5x/week x 4 weeks, 3x/week x 2 week and 2x/week x 1 week to ensure compliance.  Audit results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinuation that audits.	ng ks,	
	conducted with nu	rsing assistant (NA)-C. NA-C					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245277	B. WING		09	C / <b>11/2020</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 601 GRANT AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 880	room for breakfast additional resident room for dinner. Nothe second floor dior assistance eating was unable to mai during meals. NA-stagger meals, and to do so with the an NA-C stated a corpus suggested the facing assist with meals.  On 9/11/20, at 10:00 was conducted with additional resident in the second floor on 9/11/20, at 1:48 conducted with the The DON stated or identified as a constated residents with dining room requir assistance. The Drug fully staffed some croom at all times, resident who resident with residents requiring with eating may contain the dining room or the dini	and lunch. NA-C stated ate in the second floor dining A-C stated residents who ate in ning room required supervision ag. NA-C confirmed the facility intain six feet social distancing. C stated the facility did not a stated it would be impossible mount of staff the facility had. Corate representative lity train additional staff to a.m. a follow-up interview h LPN-C. LPN-C stated three is for a total of 18 residents, ate dining room during dinner.  By p.m. an interview was a director of nursing (DON). Communal dining had been cern by the facility. The DON ho ate in the second floor red supervision or greater ON stated when the facility was one remained in the dining The DON confirmed one red on the second floor had COVID-19 test on 9/11/20, rent did not eat in the dining Coronavirus (COVID-19) dated ommunal dining should be the guidance is provided. It is gassistance or supervision on tinue to be served meals in common area, as long as they ome of a respiratory illness.	F8	380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C			
		245277	B. WING			09/11/2020		
	PROVIDER OR SUPPLIER	L		60	REET ADDRESS, CITY, STATE, ZIP CODE  1 GRANT AVENUE  /ELETH, MN 55734	1 03/	11/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 880	maintain social dist between residents.  HAND HYGIENE  R9's quarterly MDS had severely impair dependent upon state R10's quarterly MDR10 had severely in required extensive  On 9/11/20, at 11:5 observed to be searounded table in the R9 was provided a R10 was provided a R10 was provided a 12:18 p.m. activity and R10. AA-A assistraw, and assisted towards R10, fed he fluids. AA-A again from the resident's cup of milk, assisted continued to feed the R9's spoon with a pfeed the resident. Ameal tray, faced R1 juice. AA-A asked F stood up and obtain	mpt to make every effort to ancing of at least 6 feet  dated 8/26/20, identified R9 red cognition, and was totally aff for eating.  S dated 7/13/20, identified mpaired cognition, and assistance eating.  2 a.m. R9 and R10 were ted adjacent to each other at a esecond floor commons area. meal tray at 12:11 a.m. and a meal tray at 12:13 p.m. At aide (AA)-A sat between R9 sisted R9 to drink fluids with a her to eat. AA-A turned er with a spoon, and provided aced R9, removed the straw juice, placed the straw in a d R9 drink the milk, and he resident. AA-A wiped off paper napkin, and continued to AA-A placed the spoon on R9's 10, and assisted R10 drink R9 if she would like a Kleenex, and handed to	F8	80	DEFICIENCY)			
	R9. R9 blew her not R9 and R10 and as observed wiping the protector. AA-A wip paper napkin, and a	ose. AA-A again sat between sisted R10 drink juice. R9 was e Kleenex on her clothing ed off R10's spoon with a attempted feed R10 by rubbing r lips and rubbed the resident's						
		r lips and rubbed the resident's A again faced R9 and assisted						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION IG	) ´COM	(X3) DATE SURVEY COMPLETED	
		245277	B. WING_			C / <b>11/2020</b>
	PROVIDER OR SUPPLIER	С		STREET ADDRESS, CITY, STATE, ZIP C 601 GRANT AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 880	the resident drink the turned towards R10 gave R10 a bite of again faced R9 and turned to R10 and fagain faced R9 and did not perform har above observation. R9 to her room and soap and water.  On 9/11/20, at 12:4 conducted with AA-assisted more than AA-A stated one recovided with RN expected to wash the were potentially comultiple residents. hand hygiene could On 9/11/20, at 1:48 conducted with RN expected to wash the were potentially comultiple residents. hand hygiene could On 9/11/20, at 1:48 conducted with the sometimes staff fed she expected hand prevent infection.  The facility policy H dated 8/19, directed the handwashing/higher could be a side of the conducted with the sometimes staff fed she expected hand prevent infection.	arrough a straw. AA-A then on the property of	F 88			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C		
		245277	B. WING			/11/2020	
	PROVIDER OR SUPPLIER	.c		STREET ADDRESS, CITY, STATE, ZIP CODE 601 GRANT AVENUE EVELETH, MN 55734	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 880	On 9/10/20, at 3:25 observed in the kitch preparing food. C-/eye protection nor mask properly (mapreparing food in the C-A stated she can because of person not talked to her suconcerns. C-A stated to wearing part of COVID-19 in C-A placed the factor nose, walked back resumed preparing hands after handling on 9/10/20, at 3:36 kitchen at a stainle While taking food to observed not wear protection, nor was properly (mask und foods for resident salso was observed her bare hand. C-A kitchen and it is my I am greater than 60 need to wear eye protective equipment of the come to her indicate face mask and face stated if an employ protective equipment allowed to work at employees, which is supposed in the come to her indicate face mask and face stated if an employer of the complex supposed in the	5 p.m. cook (C)-A was chen at a stainless prep table A was observed not wearing was she wearing her face sk under her chin) while he kitchen. During interview not wear a face mask al reasons, however, she had upervisor or the DON about ted she had received education mask and eye protection as infection prevention training, he mask over her mouth and to the stainless prep table and food without washing her	F 88				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		245277	B. WING			1	11/2020
	PROVIDER OR SUPPLIER	I		601	REET ADDRESS, CITY, STATE, ZIP CODE  GRANT AVENUE  ELETH, MN 55734	<u>, 557</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	kitchen staff were reface mask and eye stated there were not on 9/11/20, at 8:59 interviewed and statemployees come to wear a face mask. employees were remask and eye shiel including when in the stated all employees required to follow the guidelines regarding minimum wearing at to prevent the possion of 0/11/20, at 9:15 stated no kitchen of to her with a concent of the wear eyall times when in the kitchen preparing for staff employed at the follow PPE guideling infection control plate. The facility policy In Control Program ur Monarch Healthcar and maintain an infination of prevent the develop communicable dise further indicated the policies and process.	equired to wear at minimum a shield protection. The DON to exceptions to this policy.  It a.m. the administrator was sted there had not been any or him about not being able. The administrator stated all quired to be wearing their face ld when in the building, the kitchen. The administrator are entering the facility were the recommended CMS g PPE, which included at a face mask and eye protection sible spread of COVID  If a.m. dietary manager (DM)-A or dietary employees had come and dining staff were the protection and face mask at the facility including while in the facility were required to the sas part of the COVID-19		380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ID		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		245277	B. WING		0	C <b>09/11/2020</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 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 PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 880	•	age 14 er for Disease Control (CDC).	F	880			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 24, 2020

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

Re: State Nursing Home Licensing Orders

Event ID: 65BT11

#### Dear Administrator:

The above facility was surveyed on September 10, 2020 through September 11, 2020 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 <u>only a suggestion</u> 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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 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:

Teresa Ament, Unit Supervisor
Duluth Survey Team
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

Phone: (218) 302-6151

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 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

(X6) DATE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00583	B. WING		09/1	1/2020
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	C	NT AVENUE I, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTENTION*****					
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surve found that the deficience not corrent corrected shall	Minnesota Statute, section ction order has been issued by. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.				
	requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tag ule number indicated below. In the items will be considered a Lack of compliance upon any item of multi-part rule will the items will be even if the item uring the initial inspection was				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	survey was conduct with State Licensur	rs: h 9/11/20, an abbreviated ted to determine compliance e. Your facility was found NOT with the MN State Licensure.				
	The following comp substantiated:	olaints were found to be				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 10/03/20

TITLE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3)	DATE SURVEY COMPLETED	
			A. BOILDING.		С	
		00583	B. WING		09/11/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	C	IT AVENUE			
0/4) ID	CHIMMA DV CTA	TEMENT OF DEFICIENCIES	, MN 55734		0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MEMBER OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 1	2 000			
	H5277047C H5277048C					
	signature is not req page of state form. Although no plan of	ed in ePOC and therefore a uired at the bottom of the first correction is required, it is cility acknowledge receipt of ments.				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830		10/14/20	
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	by: Based on interview facility failed to ens properly attached to of 3 residents (R1) Findings include: R1's Admission Rec	and document review, the ure a humidification bottle was an oxygen concentrator for 1 reviewed for oxygen.		F 695 Respiratory/Tracheostomy Care and Suctioning Immediate Corrective Action: R1 was discharged on 8/29/20. Corrective Action as it applies to other The Policy for Oxygen Administration reviewed and remains current. All residents who utilize continuous oxygen with bubbler will be assessed	s: was	

Minnesota Department of Health

STATE FORM 6899 65BT11 If continuation sheet 2 of 14

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.	·	c	
		00583	B. WING		1	, 1/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	С	NT AVENUE , MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 2	2 830			
2 830	and chronic respiral deprived of oxygen R1's admission Mir 7/15/20, identified FMDS further indicate therapy.  R1's Order Summa indicated R1 was oper minute (LPM) was oper minute (LPM) was an alteration in oxygen and teration in oxygen in the blood R1's progress note indicated R1's physician order treatments. R1 region oxygen in the blood R1's physician order treatments. R1 region to the same low oxygen in the blood R1's physician order treatments. R1 region oxygen with his oxygen with his oxygen with his oxygen was changed to On 9/10/20, at 1:00 conducted with famishe received a call R1. F-A stated R1 heard R1 say, "I'm happened." F-A stated R1 heard R1 say, "I'm heard R1 sa	atory failure with hypoxia (body) and emphysema.  Inimum Data Set (MDS) dated R1 had intact cognition. R1's ted he received oxygen  In y Report dated 9/11/20, redered oxygen at nine liters with use of a nasal cannula.  In which is a care plan minister oxygen as ordered.  In dated 7/29/20, at 10:11 a.m. sician was notified R1 had saturations (measurement of distream) during the morning. In the event there was a cygen concentrator.  In the event there was a cygen concentrator.		ensure that bubbler is intact with concentrator and patent. All nurses will be re-educated on administration. Date of Compliance: 10/14/20 Recurrence will be prevented by: Audits will begin on all residents witlize oxygen with a bubbler will of 5x/week x 4 weeks, 3x/week x 2 wand 2x/week x 1 week to ensure to oxygen system is patent and funch Audit results will be shared with the QAPI committee for input on the rincrease, decrease or discontinue audits.	who ccur veeks, hat tioning. le facility need to	
	approximately 25 m voicemail, and he a	ninutes after she received the answered the phone. F-A nis fingers were blue. F-A				

Minnesota Department of Health

STATE FORM 6899 65BT11 If continuation sheet 3 of 14

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. BOILDING.		С	
		00583	B. WING			1/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	C	NT AVENUE , MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	stated she overheal him to a portable or was told by a facility incident, a humidiffus crewed on the oxy not received oxyger.  On 9/10/20, at 1:39 conducted with lice LPN-A stated R1 with his oxygen durhad called F-A about the called to R1's room R1's toes were discolored, however change from R1's room R1's toes were discolored, however change from R1's room saturation. LPN-B was in the 80's (not stated she then called to R1's room saturation. LPN-B was in the 80's (not stated she then called the called the called the stated she then called the stated she	rd staff say they connected kygen tank. F-A stated she y staff-person after the cation bottle was not properly gen concentrator, and R1 had n due to this.  I. p.m. an interview was nsed practical nurse (LPN-A). as concerned about an issue ing the day on 7/29/20, and he ut it.  I. p.m. an interview was N-B. LPN-B stated she was on 7/29/20, as staff reported colored. LPN-B stated she and confirmed they were er, verbalized this was not a normal condition. LPN-B stated R1's room. LPN-B stated R1's toes became increasingly inutes later. LPN-B stated she m and obtained an oxygen stated R1's oxygen saturation rmal is 90-100%). LPN-B led the on-call nurse and I to be sent to the hospital. n-call nurse told her there was en saturation was that low. hen instructed staff to connect to a portable oxygen tank. alled F-A during the incident to N-B stated nursing assistant her a humidification bottle was rrectly" when she changed	2 830			
		director of nursing (DON).				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00583	B. WING		C <b>09/11/2020</b>	
					03/1	1/2020
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S I <b>T AVENUE</b>	STATE, ZIP CODE		
THE WA	THE WATERVIEW WOODS LLC EVELETI					
(V4) ID	STIMMADV STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 4	2 830			
	The DON stated NAR1's oxygen concerstated R1's feet turn abnormal for the reaportable oxygen to stated a nurse verb staff who were in R humidification bottle screwed on the oxyconfirmed no other DON stated NAS' homogetency evaluated was unsure if a valic completed with NAcompleted. The DO	A-B screwed a "bubbler" to ntrator "improperly." The DON ned purple, which was not sident, and he was placed on ank "right away." The DON ally educated NA-B and other 1's room, when the was found to be incorrectly gen concentrator. The DON staff were educated. The ad oxygen therapy tions completed, however, dation competency was -B after verbal education was DN staff meeting, however, was				
	conducted with NA-R1's room at appro and noticed R1's fir blue. NA-A stated I wasn't getting air. I phone with F-A duri notified the nurse a oxygen concentrate and recovered with stated NA-B change R1's oxygen concectified she iden was not correctly so concentrator and oxygen concentrator and					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00583	B. WING		C <b>09/11/2020</b>	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE WAT	TERVIEW WOODS LL	C	IT AVENUE , MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
2 830	Continued From pa	ge 5	2 830			
	oxygen therapy incl monitoring, use and care and cleaning of	cies and procedures covering uding administration, I effectiveness, precautions, of equipment.				
	The DON, or design implementation of t physician orders rel oxygen therapy. The or designee, could a policies/procedures	nee, could train staff in he policies, care plans, and ated to the provision of he director of nursing (DON), develop or revise related to provision of oxygen or designee, could perform				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375		10/14/20	
	home must establis	n control program. A nursing h and maintain an infection signed to provide a safe and nt.				
	by: Based on observati review, the facility fa ensure social distar 18 (R7, R8) residen dining. In addition, thand hygiene after contaminated surfa assistance for 2 of reviewed for activiti	ent is not met as evidenced on, interview, and document ailed to provide supervision to noing was maintained for 2 of its reviewed for communal he facility failed to perform direct contact with ces and after providing eating 3 residents (R9, R10) es of daily living (ADLs). In failed to ensure dietary staff		F 880 Infection Prevention and Collimmediate Corrective Action: All residents will be assisted to eat rooms. NARs involved were educaneed to sanitize hands in between residents and when coming in consurfaces other than the utensils us eating. Kitchen staff member was educated on need to wear eye profimask, and washing hands if touching	in their ited on feeding tact with ed for tection,	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00583	B. WING		C 09/11/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
THF WA	TERVIEW WOODS LL	С	IT AVENUE			
<b>.</b>	LICVIEW WOODO EE	EVELETH	, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
21375	Continued From pa	ge 6	21375			
21375	were wearing prope equipment (PPE) to COVID-19 according Control (CDC) guid the potential to affer in the facility.  Findings include:  COMMUNAL DINING R7's quarterly Mining 8/10/20, identified Fimpairment and receating.  R7's care plan date risk for COVID-19, maintaining social of the second second second second control of the second secon	er personal protective or prevent the spread of ag to Centers for Disease delines. These practices had cot all 57 residents who resided of ag to Centers for Disease delines. These practices had cot all 57 residents who resided of a severe cognitive quired limited assistance of a 3/17/20, indicated R7 was at and was non-compliant distancing with other residents. Itated 7/9/20, identified R8 had apairment and required of a 3/17/20, indicated R8 was at and was non-compliant distancing with other residents. If a.m. an interview was administrator. The distancing the facility was conducting due to four newly confirmed a the facility. The administrator of cases were identified on the	21375	mask or other surfaces prior to prefood. Corrective Action as it applies to of The Coronavirus Policy, Handwashing/Hand Hygiene Polici Infection Prevention and Control Policy were reviewed and remain of All resident trays will be brought to resident rooms and any residents need assistance will be assisted we eating in their rooms. Room trays for each nursing wing will be staged All NARs, Activity Aids (with NAR certification), and nurses will receive ducation on need to sanitize hand between feeding residents and who coming in contact with surfaces of the utensils used for eating.  All kitchen staff will receive education education on handwashing/sanitizing hands after touching face masks. Date of Compliance: 10/14/20 Recurrence will be prevented by: Audits will be completed to ensure resident meal trays are being deliving rooms and that residents that need assistance with eating are receiving assistance in their room. Audits will be completed to ensure that staff as sanitizing hands in between feeding residents and when coming in consurfaces other than the utensils used ting. These audits will occur 5x.	thers:  y, and rogram current.  that ith ervice ered.  ye ds in en her than ion on ice ceive ng  all ered to d g this ll also are g tact with ed for fweek x	
	observed in the sec and R8 were obser	a.m. four residents were cond floor dining room. R7 ved seated next to each other R7 and R8 had meals in front		4 weeks, 3x/week x 2 weeks, and x 1 week to ensure compliance.  Audits will be completed to ensure kitchen staff are wearing eye prote and face mask at all times and are	all ction	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	
			71. BOILBING.		C	
		00583	B. WING		1	1/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	C	NT AVENUE , MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 7	21375			
	of them, and were within arm's reach of each other. No staff were present or near the dining room.			washing/sanitizing hands after too face mask. These audits will occu 5x/week x 4 weeks, 3x/week x 2 v and 2x/week x 1 week to ensure	ır	
	conducted with regiconfirmed no staff of floor dining room, a were approximately RN-A stated resided second floor dining RN-A stated resided room as the facility stated COVID-19 to second floor on 9/1 in the facility. RN-A awaiting COVID-19 resided on the second floor din facility was a conducted with lice LPN-C stated approaches the second floor dir facility did not staggate in the dining room confirmed the facility feet social distancinall residents who at room required supereating. LPC-C stated dining room, and the each table.	a.m. an interview was nsed practical nurse (LPN)-C. eximately 15 residents ate in ning room. LPN-C stated the ger meals, and all residents om at the same time. LPN-C ty was unable to maintain six ng during meals. LPN-C stated e in the second floor dining ervision or needed assistance ed there were five tables in the nree residents were placed at a.m. an interview was		and 2x/week x 1 week to ensure compliance.  Audit results will be shared with the QAPI committee for input on the results.	need to	
	conducted with nurs stated 15 residents room for breakfast	sing assistant (NA)-C. NA-C ate in the second floor dining and lunch. NA-C stated ate in the second floor dining				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					С	
		00583	B. WING		09/1	1/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	C	IT AVENUE , MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	room for dinner. NA the second floor dir or assistance eating was unable to main during meals. NA-0 stagger meals, and to do so with the ar NA-C stated a corp suggested the facilit assist with meals.  On 9/11/20, at 10:0 was conducted with additional residents in the second floor  On 9/11/20, at 1:48 conducted with the The DON stated co identified as a cond stated residents wh dining room require assistance. The DO fully staffed someor room at all times. resident who reside tested positive for O however, the reside room.  The facility policy O 7/23/20, directed co canceled until furth Residents requiring with eating may cor the dining room or are without sympto. The facility will atter	A-C stated residents who ate in hing room required supervision g. NA-C confirmed the facility stain six feet social distancing C stated the facility did not stated it would be impossible mount of staff the facility had. The facility had to representative fity train additional staff to a.m. a follow-up interview a LPN-C. LPN-C stated three for a total of 18 residents, ate dining room during dinner.  p.m. an interview was director of nursing (DON). The DON to ate in the second floor and supervision or greater and stated when the facility was the remained in the dining are polylocated to the second floor had covided to the second floor had covided to the second floor had covided are guidance is provided. It is assistance or supervision and the to be served meals in common area, as long as they must be make every effort to ancing of at least 6 feet.	21375			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
			A. BUILDING:				
		00583	B. WING		09/1	; 1/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
THE WA	THE WATERVIEW WOODS LLC 601 GRANT AVENUE						
		EVELETH	, MN 55734				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21375	Continued From pa	ge 9	21375				
	HAND HYGIENE						
	R9's quarterly MDS dated 8/26/20, identified R9 had severely impaired cognition, and was totally dependent upon staff for eating.						
		S dated 7/13/20, identified mpaired cognition, and assistance eating.					
	On 9/11/20, at 11:52 a.m. R9 and R10 were observed to be seated adjacent to each other at a rounded table in the second floor commons area. R9 was provided a meal tray at 12:11 a.m. and R10 was provided a meal tray at 12:13 p.m. At 12:18 p.m. activity aide (AA)-A sat between R9 and R10. AA-A assisted R9 to drink fluids with a straw, and assisted her to eat. AA-A turned towards R10, fed her with a spoon, and provided fluids. AA-A again faced R9, removed the straw						
	cup of milk, assiste continued to feed the R9's spoon with a preded the resident. A meal tray, faced R1 juice. AA-A asked F	juice, placed the straw in a d R9 drink the milk, and he resident. AA-A wiped off paper napkin, and continued to AA-A placed the spoon on R9's 10, and assisted R10 drink R9 if she would like a Kleenex, ned a Kleenex, and handed to					
	R9. R9 blew her no R9 and R10 and as observed wiping the protector. AA-A wip paper napkin, and a a spoon against he right shoulder. AA-A	ose. AA-A again sat between sisted R10 drink juice. R9 was a Kleenex on her clothing sed off R10's spoon with a attempted feed R10 by rubbing r lips and rubbed the resident's A again faced R9 and assisted					
	turned towards R10 gave R10 a bite of	nrough a straw. AA-A then ), rubbed her shoulder, and pineapple with a spoon. AA-A I fed the resident with a spoon.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00583	B. WING	C 		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	,	
THE WAT	TERVIEW WOODS LL	C	IT AVENUE , MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21375	again faced R9 and did not perform han above observation. R9 to her room and soap and water.  On 9/11/20, at 12:4 conducted with AA-assisted more than AA-A stated one rescovide and hygiene when eat.  On 9/11/20, at 1:27 conducted with RN-expected to wash the were potentially comultiple residents. hand hygiene could On 9/11/20, at 1:48 conducted with the sometimes staff fees she expected hand prevent infection.  The facility policy H dated 8/19, directed the handwashing/hahelp prevent the spersonnel, resident PPE  On 9/10/20, at 3:25 observed in the kito	ed her with a spoon, and I fed her with a spoon. AA-A and hygiene throughout the At 12:42 p.m., AA-A wheeled performed hand hygiene with Bar. A. AA-A stated staff normally one resident eat at a time. Sident on the second floor had onfirmed she did not perform she assisted R9 and R10 to p.m. an interview was A. RN-A stated staff were neir hands when their hands attaminated and they fed RN-A stated failure to perform cause "spreading."  p.m. an interview was DON. The DON stated I more than one resident, and washing to be performed to andwashing/Hand Hygiene d, "All personnel shall follow and hygiene procedures to read of infections to other	21375			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00583	B. WING		1	1/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	C	IT AVENUE , MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	mask properly (maspreparing food in the C-A stated she can because of personal not talked to her succoncerns. C-A state related to wearing hands after handlin.  On 9/10/20, at 3:36 kitchen at a stainles While taking food to observed not wearing protection, nor was properly (mask und foods for resident salso was observed her bare hand. C-A kitchen and it is my I am greater than 6 need to wear eye poon 9/1120, at 7:13 and stated there had come to her indicate face mask and face stated if an employer protective equipme allowed to work at the employees, which i licensed staff activity kitchen staff were reface mask and eye stated there were not stated the not stated there were not stated the not stated there were not stated the	sk under her chin) while le kitchen. During interview not wear a face mask al reasons, however, she had pervisor or the DON about ed she had received education mask and eye protection as affection prevention training. It mask over her mouth and to the stainless prep table and food without washing her	21375			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00583	B. WING		<b>I</b>	C <b>11/2020</b>
NAME OF PROVIDER OR SUPPLIER  THE WATERVIEW WOODS LLC  STREET ADDRESS, CITY, STATE, ZIP CODE  601 GRANT AVENUE  EVELETH, MN 55734						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21375	interviewed and state employees come to wear a face mask. employees were remask and eye shiel including when in the stated all employees required to follow the guidelines regarding minimum wearing at to prevent the poss.  On 9/11/20, at 9:15 stated no kitchen of to her with a concert of the wear eyall times when in the kitchen preparing for staff employed at the follow PPE guideling infection control plate.  The facility policy In Control Program und maintain an information of the control program (IPCP) desanitary and comformation of the develop communicable disect further indicated the policies and proceded and will follow disect those of the Center SUGGESTED MET The Director of Nurdevelop systems to	ted there had not been any him about not being able. The administrator stated all quired to be wearing their face d when in the building, he kitchen. The administrator is entering the facility were he recommended CMS g PPE, which included at a face mask and eye protection ible spread of COVID  a.m. dietary manager (DM)-A or dietary employees had come or about inability to wear PPE, when and dining staff were the protection and face mask at the facility including while in bood. DM-A further stated all the facility were required to the sas part of the COVID-19	21375			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		00583	B. WING		I	C <b>11/2020</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	C:	NT AVENUE I, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21375	or designee, could on implementation based precautions hygiene needs to be Nursing, or designe appropriate staff on The Director of Nurdevelop monitoring compliance.	ge 13 educate all appropriate staff of appropriate transmission and indications when hand e performed. The Director of ee, could educate all the policies and procedures. sing, or designee, could systems to ensure ongoing  R CORRECTION: Twenty-one	21375			

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