DEPARTMENT OF HEALTH

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

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

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	C 09/11/2020

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 A COVID-19 Focused Infection Control survey was conducted 9/10/20, through 9/11/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations § 483.73(b)(6). The facility was in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facilty acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/10/20, through 9/11/20, an abbreviated survey and a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The survey identified the facility was NOT in compliance. The following complaints were substantiated: H5277047C H5277048C 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. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(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.

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a humidification bottle was properly attached to an oxygen concentrator for 1 of 3 residents (R1) reviewed for oxygen. Findings include: R1's Admission Record dated 9/11/20, indicated R1's diagnoses included acute (sudden onset) and chronic respiratory failure with hypoxia (body deprived of oxygen) and emphysema. R1's admission Minimum Data Set (MDS) dated 7/15/20, identified R1 had intact cognition. R1's MDS further indicated he received oxygen therapy. R1's Order Summary Report dated 9/11/20,	F 695	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 was 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,	10/14/20

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F 695	Continued From page 2 indicated R1 was ordered oxygen at nine liters per minute (LPM) with use of a nasal cannula. R1's care plan resolved 7/22/20, indicated R1 had an alteration in oxygen/gas exchange related to respiratory failure and hypoxia. The care plan directed staff to administer oxygen as ordered. R1's progress note dated 7/29/20, at 10:11 a.m. indicated R1's physician was notified R1 had "some low" oxygen saturations (measurement of oxygen in the bloodstream) during the morning. R1's physician ordered scheduled nebulizer treatments. R1 requested to have an oxygen tank left in his room in the event there was a problem with his oxygen concentrator. A physician's note dated 8/4/20, indicated R1's humidifier "did not work" one day of the week, and R1's oxygen saturation fell below 60% until he was changed to a reserve oxygen tank. On 9/10/20, at 1:00 p.m., an interview was conducted with family member (F)-A. F-A stated she received a call on 7/29/20, at 6:30 a.m. from R1. F-A stated R1 had left a voicemail and she heard R1 say, "I'm dying" and "I don't know what happened." F-A stated she called R1 approximately 25 minutes after she received the voicemail, and he answered the phone. F-A stated R1 told her his fingers were blue. F-A stated she overheard staff say they connected him to a portable oxygen tank. F-A stated she was told by a facility staff-person after the incident, a humidification bottle was not properly screwed on the oxygen concentrator, and R1 had not received oxygen due to this. On 9/10/20, at 1:39 p.m. an interview was	F 695	and 2x/week x 1 week to ensure that oxygen system is patent and functioning. Audit results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.	

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F 695	Continued From page 3	F 695		

conducted with licensed practical nurse (LPN-A). LPN-A stated R1 was concerned about an issue with his oxygen during the day on 7/29/20, and he had called F-A about it.

On 9/10/20, at 1:57 p.m. an interview was conducted with LPN-B. LPN-B stated she was called to R1's room on 7/29/20, as staff reported R1's toes were discolored. LPN-B stated she looked at R1's toes and confirmed they were discolored, however, verbalized this was not a change from R1's normal condition. LPN-B stated she then exited R1's room. LPN-B stated staff informed her R1's toes became increasingly discolored a few minutes later. LPN-B stated she reentered R1's room and obtained an oxygen saturation. LPN-B stated R1's oxygen saturation was in the 80's (normal is 90-100%). LPN-B stated she then called the on-call nurse and asked if R1 needed to be sent to the hospital. LPN-B stated the on-call nurse told her there was "no way" R1's oxygen saturation was that low. LPN-B stated she then instructed staff to connect R1's oxygen tubing to a portable oxygen tank. LPN-B stated R1 called F-A during the incident to say "goodbye." LPN-B stated nursing assistant (NA)-A reported to her a humidification bottle was "not screwed on correctly" when she changed R1's oxygen tubing.

On 9/11/20, at 10:18 a.m. an interview was conducted with the director of nursing (DON). The DON stated NA-B screwed a "bubbler" to R1's oxygen concentrator "improperly." The DON stated R1's feet turned purple, which was not abnormal for the resident, and he was placed on a portable oxygen tank "right away." The DON stated a nurse verbally educated NA-B and other staff who were in R1's room, when the

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F 695	Continued From page 4 humidification bottle was found to be incorrectly screwed on the oxygen concentrator. The DON confirmed no other staff were educated. The DON stated NAs' had oxygen therapy competency evaluations completed, however, was unsure if a validation competency was completed with NA-B after verbal education was completed. The DON stated the facility wanted to conduct a mandatory staff meeting, however, was unable due to COVID-19. On 9/11/20, at 11:14 a.m. an interview was conducted with NA-A. NA-A stated she entered R1's room at approximately 6:25 a.m. on 7/29/20, and noticed R1's fingers, toes, and nose were blue. NA-A stated R1 told her he felt like he wasn't getting air. NA-A stated R1 was on the phone with F-A during this time. NA-A stated she notified the nurse and R1 was switched from the oxygen concentrator to a portable oxygen tank, and recovered within a couple of minutes. NA-A stated NA-B changed a humidification bottle on R1's oxygen concentrator during nightshift. NA-A confirmed she identified the humidification bottle was not correctly screwed on R1's oxygen concentrator and oxygen leaked out. NA-B was not available for interview. The facility policy Oxygen General Guidelines undated, directed, "The Director of Nursing and the Occupational Health Director shall be responsible for arranging the education of nursing staff regarding policies and procedures covering oxygen therapy including administration, monitoring, use and effectiveness, precautions, care and cleaning of equipment.	F 695		
F 880 SS=F	Infection Prevention & Control	F 880		10/14/20

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F 880	Continued From page 5 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 6 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide supervision to ensure social distancing was maintained for 2 of 18 (R7, R8) residents reviewed for communal dining. In addition, the facility failed to perform hand hygiene after direct contact with contaminated surfaces and after providing eating assistance for 2 of 3 residents (R9, R10) reviewed for activities of daily living (ADLs). In addition, the facility failed to ensure dietary staff	F 880	F 880 Infection Prevention and Control Immediate Corrective Action: All residents will be assisted to eat in their rooms. NARs involved were educated on need to sanitize hands in between feeding residents and when coming in contact with surfaces other than the utensils used for eating. Kitchen staff member was educated on need to wear eye protection, mask, and washing hands if touching face	

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F 880	Continued From page 7 were wearing proper personal protective equipment (PPE) to prevent the spread of COVID-19 according to Centers for Disease Control (CDC) guidelines. These practices had the potential to affect all 57 residents who resided in the facility. Findings include: COMMUNAL DINING R7's quarterly Minimum Data Set (MDS) dated 8/10/20, identified R7 had a severe cognitive impairment and required limited assistance eating. R7's care plan dated 3/17/20, indicated R7 was at risk for COVID-19, and was non-compliant maintaining social distancing with other residents. R8's annual MDS dated 7/9/20, identified R8 had severe cognitive impairment and required supervision eating. R8's care plan dated 3/17/20, indicated R8 was at risk for COVID-19, and was non-compliant maintaining social distancing with other residents. On 9/10/20, at 8:37 a.m. an interview was conducted with the administrator. The administrator stated the facility was conducting COVID-19 testing due to four newly confirmed COVID-19 cases in the facility. The administrator stated all COVID-19 cases were identified on the first floor of the facility. On 9/11/20, at 9:00 a.m. four residents were observed in the second floor dining room. R7 and R8 were observed seated next to each other	F 880	mask or other surfaces prior to preparing food. Corrective Action as it applies to others: The Coronavirus Policy, Handwashing/Hand Hygiene Policy, and Infection Prevention and Control Program Policy were reviewed and remain current. All resident trays will be brought to resident rooms and any residents that need assistance will be assisted with eating in their rooms. Room tray service for each nursing wing will be staggered. All NARs, Activity Aids (with NAR certification), and nurses will receive education on need to sanitize hands in between feeding residents and when coming in contact with surfaces other than the utensils used for eating. All kitchen staff will receive education on need to wear eye protection and face mask at all times. They will also receive 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 all resident meal trays are being delivered to rooms and that residents that need assistance with eating are receiving this assistance in their room. Audits will also be completed to ensure that staff are sanitizing hands in between feeding residents and when coming in contact with surfaces other than the utensils used for eating. These audits will occur 5x/week x 4 weeks, 3x/week x 2 weeks, and 2x/week x 1 week to ensure compliance. Audits will be completed to ensure all	

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	245277	A. BUILDING _____ B. WING _____	C 09/11/2020

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F 880	Continued From page 8 at a rounded table. R7 and R8 had meals in front of them, and were within arm's reach of each other. No staff were present or near the dining room. On 9/11/20, at 9:06 a.m. an interview was conducted with registered nurse (RN)-A. RN-A confirmed no staff were present in the second floor dining room, and she estimated R7 and R8 were approximately two and one-half feet apart. RN-A stated residents who were eating in the second floor dining room required prompting. RN-A stated residents were eating in the dining room as the facility had staffing issues. RN-A stated COVID-19 testing was completed on the second floor on 9/10/20, due to confirmed cases in the facility. RN-A stated the facility was awaiting COVID-19 results for residents who resided on the second floor. RN-A stated "a couple" of residents also still needed to be tested as the facility was awaiting consent. On 9/11/20, at 9:53 a.m. an interview was conducted with licensed practical nurse (LPN)-C. LPN-C stated approximately 15 residents ate in the second floor dining room. LPN-C stated the facility did not stagger meals, and all residents ate in the dining room at the same time. LPN-C confirmed the facility was unable to maintain six feet social distancing during meals. LPN-C stated all residents who ate in the second floor dining room required supervision or needed assistance eating. LPC-C stated there were five tables in the dining room, and three residents were placed at each table. On 9/11/20, at 9:59 a.m. an interview was conducted with nursing assistant (NA)-C. NA-C stated 15 residents ate in the second floor dining	F 880	kitchen staff are wearing eye protection and face mask at all times and are washing/sanitizing hands after touching face mask. These audits will occur 5x/week x 4 weeks, 3x/week x 2 weeks, 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 discontinue the audits.	

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F 880	Continued From page 9	F 880		

room for breakfast and lunch. NA-C stated additional residents ate in the second floor dining room for dinner. NA-C stated residents who ate in the second floor dining room required supervision or assistance eating. NA-C confirmed the facility was unable to maintain six feet social distancing during meals. NA-C stated the facility did not stagger meals, and stated it would be impossible to do so with the amount of staff the facility had. NA-C stated a corporate representative suggested the facility train additional staff to assist with meals.

On 9/11/20, at 10:04 a.m. a follow-up interview was conducted with LPN-C. LPN-C stated three additional residents for a total of 18 residents, ate in the second floor dining room during dinner.

On 9/11/20, at 1:48 p.m. an interview was conducted with the director of nursing (DON). The DON stated communal dining had been identified as a concern by the facility. The DON stated residents who ate in the second floor dining room required supervision or greater assistance. The DON stated when the facility was fully staffed someone remained in the dining room at all times. The DON confirmed one resident who resided on the second floor had tested positive for COVID-19 test on 9/11/20, however, the resident did not eat in the dining room.

The facility policy Coronavirus (COVID-19) dated 7/23/20, directed communal dining should be canceled until further guidance is provided. Residents requiring assistance or supervision with eating may continue to be served meals in the dining room or common area, as long as they are without symptoms of a respiratory illness.

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F 880	Continued From page 10	F 880		

The facility will attempt to make every effort to maintain social distancing of at least 6 feet between residents.

HAND HYGIENE

R9's quarterly MDS dated 8/26/20, identified R9 had severely impaired cognition, and was totally dependent upon staff for eating.

R10's quarterly MDS dated 7/13/20, identified R10 had severely impaired cognition, and required extensive 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 from the resident's juice, placed the straw in a cup of milk, assisted R9 drink the milk, and continued to feed the resident. AA-A wiped off R9's spoon with a paper napkin, and continued to feed the resident. AA-A placed the spoon on R9's meal tray, faced R10, and assisted R10 drink juice. AA-A asked R9 if she would like a Kleenex, stood up and obtained a Kleenex, and handed to R9. R9 blew her nose. AA-A again sat between R9 and R10 and assisted R10 drink juice. R9 was observed wiping the Kleenex on her clothing protector. AA-A wiped off R10's spoon with a paper napkin, and attempted feed R10 by rubbing a spoon against her lips and rubbed the resident's right shoulder. AA-A again faced R9 and assisted

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F 880	Continued From page 11	F 880		

the resident drink through a straw. AA-A then turned towards R10, rubbed her shoulder, and gave R10 a bite of pineapple with a spoon. AA-A again faced R9 and fed the resident with a spoon, turned to R10 and fed her with a spoon, and again faced R9 and fed her with a spoon. AA-A did not perform hand hygiene throughout the above observation. At 12:42 p.m., AA-A wheeled R9 to her room and performed hand hygiene with soap and water.

On 9/11/20, at 12:43 p.m. an interview was conducted with AA-A. AA-A stated staff normally assisted more than one resident eat at a time. AA-A stated one resident on the second floor had COVID-19. AA-A confirmed she did not perform hand hygiene when she assisted R9 and R10 to eat.

On 9/11/20, at 1:27 p.m. an interview was conducted with RN-A. RN-A stated staff were expected to wash their hands when their hands were potentially contaminated and they fed multiple residents. RN-A stated failure to perform hand hygiene could cause "spreading."

On 9/11/20, at 1:48 p.m. an interview was conducted with the DON. The DON stated sometimes staff fed more than one resident, and she expected hand washing to be performed to prevent infection.

The facility policy Handwashing/Hand Hygiene dated 8/19, directed, "All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.
PPE

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F 880	Continued From page 12 On 9/10/20, at 3:25 p.m. cook (C)-A was observed in the kitchen at a stainless prep table preparing food. C-A was observed not wearing eye protection nor was she wearing her face mask properly (mask under her chin) while preparing food in the kitchen. During interview C-A stated she can not wear a face mask because of personal reasons, however, she had not talked to her supervisor or the DON about concerns. C-A stated she had received education related to wearing mask and eye protection as part of COVID-19 infection prevention training. C-A placed the face mask over her mouth and nose, walked back to the stainless prep table and resumed preparing food without washing her hands after handling her face mask. On 9/10/20, at 3:36 p.m. C-A was observed in the kitchen at a stainless steam table temping foods. While taking food temperatures, C-A was observed not wearing gloves, not wearing eye protection, nor was she wearing her face mask properly (mask under her chin) while temping foods for resident supper meal service. C-A was also was observed rubbing under her nose with her bare hand. C-A stated, "I'm alone in the kitchen and it is my understanding that as long as I am greater than 6 feet from someone I do not need to wear eye protection or face mask." On 9/1120, at 7:13 a.m. the DON was interviewed and stated there had not been any employees come to her indicating their inability to wear a face mask and face shield/goggles. The DON stated if an employee could not wear personal protective equipment (PPE), they would be not be allowed to work at the facility. The DON stated all employees, which included direct care staff, licensed staff activities, housekeeping, and	F 880		

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F 880	Continued From page 13	F 880		

kitchen staff were required to wear at minimum a face mask and eye shield protection. The DON stated there were no exceptions to this policy.

On 9/11/20, at 8:59 a.m. the administrator was interviewed and stated there had not been any employees come to him about not being able wear a face mask. The administrator stated all employees were required to be wearing their face mask and eye shield when in the building, including when in the kitchen. The administrator stated all employees entering the facility were required to follow the recommended CMS guidelines regarding PPE, which included at a minimum wearing a face mask and eye protection to prevent the possible spread of COVID

On 9/11/20, at 9:15 a.m. dietary manager (DM)-A stated no kitchen or dietary employees had come to her with a concern about inability to wear PPE. DM-A stated all kitchen and dining staff were required to wear eye protection and face mask at all times when in the facility including while in kitchen preparing food. DM-A further stated all staff employed at the facility were required to follow PPE guidelines as part of the COVID-19 infection control plan.

The facility policy Infection Prevention and Control Program undated, directed the mission of Monarch Healthcare Management is to establish and maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. The policy further indicated the facility's infection control policies and procedures apply to all personnel and will follow disease-specific guidelines such as

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F 880	Continued From page 14 those of the Center for Disease Control (CDC).	F 880		

DEPARTMENT OF HEALTH

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 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:

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

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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 9/10/20, through 9/11/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found NOT to be in compliance with the MN State Licensure. The following complaints were found to be substantiated:	2 000		

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2 000	Continued From page 1 H5277047C H5277048C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	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. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a humidification bottle was properly attached to an oxygen concentrator for 1 of 3 residents (R1) reviewed for oxygen. Findings include: R1's Admission Record dated 9/11/20, indicated R1's diagnoses included acute (sudden onset)	2 830	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 was reviewed and remains current. All residents who utilize continuous oxygen with bubbler will be assessed to	10/14/20

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2 830	Continued From page 2 and chronic respiratory failure with hypoxia (body deprived of oxygen) and emphysema. R1's admission Minimum Data Set (MDS) dated 7/15/20, identified R1 had intact cognition. R1's MDS further indicated he received oxygen therapy. R1's Order Summary Report dated 9/11/20, indicated R1 was ordered oxygen at nine liters per minute (LPM) with use of a nasal cannula. R1's care plan resolved 7/22/20, indicated R1 had an alteration in oxygen/gas exchange related to respiratory failure and hypoxia. The care plan directed staff to administer oxygen as ordered. R1's progress note dated 7/29/20, at 10:11 a.m. indicated R1's physician was notified R1 had "some low" oxygen saturations (measurement of oxygen in the bloodstream) during the morning. R1's physician ordered scheduled nebulizer treatments. R1 requested to have an oxygen tank left in his room in the event there was a problem with his oxygen concentrator. A physician's note dated 8/4/20, indicated R1's humidifier "did not work" one day of the week, and R1's oxygen saturation fell below 60% until he was changed to a reserve oxygen tank. On 9/10/20, at 1:00 p.m., an interview was conducted with family member (F)-A. F-A stated she received a call on 7/29/20, at 6:30 a.m. from R1. F-A stated R1 had left a voicemail and she heard R1 say, "I'm dying" and "I don't know what happened." F-A stated she called R1 approximately 25 minutes after she received the voicemail, and he answered the phone. F-A stated R1 told her his fingers were blue. F-A	2 830	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, and 2x/week x 1 week to ensure that oxygen system is patent and functioning. Audit results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.	

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2 830	Continued From page 3	2 830		

stated she overheard staff say they connected him to a portable oxygen tank. F-A stated she was told by a facility staff-person after the incident, a humidification bottle was not properly screwed on the oxygen concentrator, and R1 had not received oxygen due to this.

On 9/10/20, at 1:39 p.m. an interview was conducted with licensed practical nurse (LPN-A). LPN-A stated R1 was concerned about an issue with his oxygen during the day on 7/29/20, and he had called F-A about it.

On 9/10/20, at 1:57 p.m. an interview was conducted with LPN-B. LPN-B stated she was called to R1's room on 7/29/20, as staff reported R1's toes were discolored. LPN-B stated she looked at R1's toes and confirmed they were discolored, however, verbalized this was not a change from R1's normal condition. LPN-B stated she then exited R1's room. LPN-B stated staff informed her R1's toes became increasingly discolored a few minutes later. LPN-B stated she reentered R1's room and obtained an oxygen saturation. LPN-B stated R1's oxygen saturation was in the 80's (normal is 90-100%). LPN-B stated she then called the on-call nurse and asked if R1 needed to be sent to the hospital. LPN-B stated the on-call nurse told her there was "no way" R1's oxygen saturation was that low. LPN-B stated she then instructed staff to connect R1's oxygen tubing to a portable oxygen tank. LPN-B stated R1 called F-A during the incident to say "goodbye." LPN-B stated nursing assistant (NA)-A reported to her a humidification bottle was "not screwed on correctly" when she changed R1's oxygen tubing.

On 9/11/20, at 10:18 a.m. an interview was conducted with the director of nursing (DON).

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2 830	Continued From page 4 The DON stated NA-B screwed a "bubbler" to R1's oxygen concentrator "improperly." The DON stated R1's feet turned purple, which was not abnormal for the resident, and he was placed on a portable oxygen tank "right away." The DON stated a nurse verbally educated NA-B and other staff who were in R1's room, when the humidification bottle was found to be incorrectly screwed on the oxygen concentrator. The DON confirmed no other staff were educated. The DON stated NAs' had oxygen therapy competency evaluations completed, however, was unsure if a validation competency was completed with NA-B after verbal education was completed. The DON stated the facility wanted to conduct a mandatory staff meeting, however, was unable due to COVID-19. On 9/11/20, at 11:14 a.m. an interview was conducted with NA-A. NA-A stated she entered R1's room at approximately 6:25 a.m. on 7/29/20, and noticed R1's fingers, toes, and nose were blue. NA-A stated R1 told her he felt like he wasn't getting air. NA-A stated R1 was on the phone with F-A during this time. NA-A stated she notified the nurse and R1 was switched from the oxygen concentrator to a portable oxygen tank, and recovered within a couple of minutes. NA-A stated NA-B changed a humidification bottle on R1's oxygen concentrator during nightshift. NA-A confirmed she identified the humidification bottle was not correctly screwed on R1's oxygen concentrator and oxygen leaked out. NA-B was not available for interview. The facility policy Oxygen General Guidelines undated, directed, "The Director of Nursing and the Occupational Health Director shall be responsible for arranging the education of nursing	2 830		

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2 830	Continued From page 5 staff regarding policies and procedures covering oxygen therapy including administration, monitoring, use and effectiveness, precautions, care and cleaning of equipment. SUGGESTED METHOD OF CORRECTION: The DON, or designee, could train staff in implementation of the policies, care plans, and physician orders related to the provision of oxygen therapy. The director of nursing (DON), or designee, could develop or revise policies/procedures related to provision of oxygen therapy. The DON, or designee, could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide supervision to ensure social distancing was maintained for 2 of 18 (R7, R8) residents reviewed for communal dining. In addition, the facility failed to perform hand hygiene after direct contact with contaminated surfaces and after providing eating assistance for 2 of 3 residents (R9, R10) reviewed for activities of daily living (ADLs). In addition, the facility failed to ensure dietary staff	21375	F 880 Infection Prevention and Control Immediate Corrective Action: All residents will be assisted to eat in their rooms. NARs involved were educated on need to sanitize hands in between feeding residents and when coming in contact with surfaces other than the utensils used for eating. Kitchen staff member was educated on need to wear eye protection, mask, and washing hands if touching face	10/14/20

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were wearing proper personal protective equipment (PPE) to prevent the spread of COVID-19 according to Centers for Disease Control (CDC) guidelines. These practices had the potential to affect all 57 residents who resided in the facility.

Findings include:

COMMUNAL DINING

R7's quarterly Minimum Data Set (MDS) dated 8/10/20, identified R7 had a severe cognitive impairment and required limited assistance eating.

R7's care plan dated 3/17/20, indicated R7 was at risk for COVID-19, and was non-compliant maintaining social distancing with other residents.

R8's annual MDS dated 7/9/20, identified R8 had severe cognitive impairment and required supervision eating.

R8's care plan dated 3/17/20, indicated R8 was at risk for COVID-19, and was non-compliant maintaining social distancing with other residents.

On 9/10/20, at 8:37 a.m. an interview was conducted with the administrator. The administrator stated the facility was conducting COVID-19 testing due to four newly confirmed COVID-19 cases in the facility. The administrator stated all COVID-19 cases were identified on the first floor of the facility.

On 9/11/20, at 9:00 a.m. four residents were observed in the second floor dining room. R7 and R8 were observed seated next to each other at a rounded table. R7 and R8 had meals in front

mask or other surfaces prior to preparing food.
Corrective Action as it applies to others: The Coronavirus Policy, Handwashing/Hand Hygiene Policy, and Infection Prevention and Control Program Policy were reviewed and remain current.
All resident trays will be brought to resident rooms and any residents that need assistance will be assisted with eating in their rooms. Room tray service for each nursing wing will be staggered.
All NARs, Activity Aids (with NAR certification), and nurses will receive education on need to sanitize hands in between feeding residents and when coming in contact with surfaces other than the utensils used for eating.
All kitchen staff will receive education on need to wear eye protection and face mask at all times. They will also receive 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 all resident meal trays are being delivered to rooms and that residents that need assistance with eating are receiving this assistance in their room. Audits will also be completed to ensure that staff are sanitizing hands in between feeding residents and when coming in contact with surfaces other than the utensils used for eating. These audits will occur 5x/week x 4 weeks, 3x/week x 2 weeks, and 2x/week x 1 week to ensure compliance.
Audits will be completed to ensure all kitchen staff are wearing eye protection and face mask at all times and are

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21375	Continued From page 7 of them, and were within arm's reach of each other. No staff were present or near the dining room. On 9/11/20, at 9:06 a.m. an interview was conducted with registered nurse (RN)-A. RN-A confirmed no staff were present in the second floor dining room, and she estimated R7 and R8 were approximately two and one-half feet apart. RN-A stated residents who were eating in the second floor dining room required prompting. RN-A stated residents were eating in the dining room as the facility had staffing issues. RN-A stated COVID-19 testing was completed on the second floor on 9/10/20, due to confirmed cases in the facility. RN-A stated the facility was awaiting COVID-19 results for residents who resided on the second floor. RN-A stated "a couple" of residents also still needed to be tested as the facility was awaiting consent. On 9/11/20, at 9:53 a.m. an interview was conducted with licensed practical nurse (LPN)-C. LPN-C stated approximately 15 residents ate in the second floor dining room. LPN-C stated the facility did not stagger meals, and all residents ate in the dining room at the same time. LPN-C confirmed the facility was unable to maintain six feet social distancing during meals. LPN-C stated all residents who ate in the second floor dining room required supervision or needed assistance eating. LPC-C stated there were five tables in the dining room, and three residents were placed at each table. On 9/11/20, at 9:59 a.m. an interview was conducted with nursing assistant (NA)-C. NA-C stated 15 residents ate in the second floor dining room for breakfast and lunch. NA-C stated additional residents ate in the second floor dining	21375	washing/sanitizing hands after touching face mask. These audits will occur 5x/week x 4 weeks, 3x/week x 2 weeks, 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 discontinue the audits.	

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room for dinner. NA-C stated residents who ate in the second floor dining room required supervision or assistance eating. NA-C confirmed the facility was unable to maintain six feet social distancing during meals. NA-C stated the facility did not stagger meals, and stated it would be impossible to do so with the amount of staff the facility had. NA-C stated a corporate representative suggested the facility train additional staff to assist with meals.

On 9/11/20, at 10:04 a.m. a follow-up interview was conducted with LPN-C. LPN-C stated three additional residents for a total of 18 residents, ate in the second floor dining room during dinner.

On 9/11/20, at 1:48 p.m. an interview was conducted with the director of nursing (DON). The DON stated communal dining had been identified as a concern by the facility. The DON stated residents who ate in the second floor dining room required supervision or greater assistance. The DON stated when the facility was fully staffed someone remained in the dining room at all times. The DON confirmed one resident who resided on the second floor had tested positive for COVID-19 test on 9/11/20, however, the resident did not eat in the dining room.

The facility policy Coronavirus (COVID-19) dated 7/23/20, directed communal dining should be canceled until further guidance is provided. Residents requiring assistance or supervision with eating may continue to be served meals in the dining room or common area, as long as they are without symptoms of a respiratory illness. The facility will attempt to make every effort to maintain social distancing of at least 6 feet between residents.

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21375	Continued From page 9 HAND HYGIENE R9's quarterly MDS dated 8/26/20, identified R9 had severely impaired cognition, and was totally dependent upon staff for eating. R10's quarterly MDS dated 7/13/20, identified R10 had severely impaired cognition, and required extensive 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 from the resident's juice, placed the straw in a cup of milk, assisted R9 drink the milk, and continued to feed the resident. AA-A wiped off R9's spoon with a paper napkin, and continued to feed the resident. AA-A placed the spoon on R9's meal tray, faced R10, and assisted R10 drink juice. AA-A asked R9 if she would like a Kleenex, stood up and obtained a Kleenex, and handed to R9. R9 blew her nose. AA-A again sat between R9 and R10 and assisted R10 drink juice. R9 was observed wiping the Kleenex on her clothing protector. AA-A wiped off R10's spoon with a paper napkin, and attempted feed R10 by rubbing a spoon against her lips and rubbed the resident's right shoulder. AA-A again faced R9 and assisted the resident drink through a straw. AA-A then turned towards R10, rubbed her shoulder, and gave R10 a bite of pineapple with a spoon. AA-A again faced R9 and fed the resident with a spoon,	21375		

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turned to R10 and fed her with a spoon, and again faced R9 and fed her with a spoon. AA-A did not perform hand hygiene throughout the above observation. At 12:42 p.m., AA-A wheeled R9 to her room and performed hand hygiene with soap and water.

On 9/11/20, at 12:43 p.m. an interview was conducted with AA-A. AA-A stated staff normally assisted more than one resident eat at a time. AA-A stated one resident on the second floor had COVID-19. AA-A confirmed she did not perform hand hygiene when she assisted R9 and R10 to eat.

On 9/11/20, at 1:27 p.m. an interview was conducted with RN-A. RN-A stated staff were expected to wash their hands when their hands were potentially contaminated and they fed multiple residents. RN-A stated failure to perform hand hygiene could cause "spreading."

On 9/11/20, at 1:48 p.m. an interview was conducted with the DON. The DON stated sometimes staff fed more than one resident, and she expected hand washing to be performed to prevent infection.

The facility policy Handwashing/Hand Hygiene dated 8/19, directed, "All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.

PPE

On 9/10/20, at 3:25 p.m. cook (C)-A was observed in the kitchen at a stainless prep table preparing food. C-A was observed not wearing eye protection nor was she wearing her face

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mask properly (mask under her chin) while preparing food in the kitchen. During interview C-A stated she can not wear a face mask because of personal reasons, however, she had not talked to her supervisor or the DON about concerns. C-A stated she had received education related to wearing mask and eye protection as part of COVID-19 infection prevention training. C-A placed the face mask over her mouth and nose, walked back to the stainless prep table and resumed preparing food without washing her hands after handling her face mask.

On 9/10/20, at 3:36 p.m. C-A was observed in the kitchen at a stainless steam table temping foods. While taking food temperatures, C-A was observed not wearing gloves, not wearing eye protection, nor was she wearing her face mask properly (mask under her chin) while temping foods for resident supper meal service. C-A was also was observed rubbing under her nose with her bare hand. C-A stated, "I'm alone in the kitchen and it is my understanding that as long as I am greater than 6 feet from someone I do not need to wear eye protection or face mask."

On 9/1120, at 7:13 a.m. the DON was interviewed and stated there had not been any employees come to her indicating their inability to wear a face mask and face shield/goggles. The DON stated if an employee could not wear personal protective equipment (PPE), they would be not be allowed to work at the facility. The DON stated all employees, which included direct care staff, licensed staff activities, housekeeping, and kitchen staff were required to wear at minimum a face mask and eye shield protection. The DON stated there were no exceptions to this policy.

On 9/11/20, at 8:59 a.m. the administrator was

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interviewed and stated there had not been any employees come to him about not being able wear a face mask. The administrator stated all employees were required to be wearing their face mask and eye shield when in the building, including when in the kitchen. The administrator stated all employees entering the facility were required to follow the recommended CMS guidelines regarding PPE, which included at a minimum wearing a face mask and eye protection to prevent the possible spread of COVID

On 9/11/20, at 9:15 a.m. dietary manager (DM)-A stated no kitchen or dietary employees had come to her with a concern about inability to wear PPE. DM-A stated all kitchen and dining staff were required to wear eye protection and face mask at all times when in the facility including while in kitchen preparing food. DM-A further stated all staff employed at the facility were required to follow PPE guidelines as part of the COVID-19 infection control plan.

The facility policy Infection Prevention and Control Program undated, directed the mission of Monarch Healthcare Management is to establish and maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. The policy further indicated the facility's infection control policies and procedures apply to all personnel and will follow disease-specific guidelines such as those of the Center for Disease Control (CDC).

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing, or designee, could develop systems to ensure appropriate social distancing during dining. The Director of Nursing,

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21375	Continued From page 13 or designee, could educate all appropriate staff on implementation of appropriate transmission based precautions and indications when hand hygiene needs to be performed. 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.	21375		