

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 18, 2021

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

RE: CCN: 245277 Cycle Start Date: January 12, 2021

Dear Administrator:

On January 22, 2021, we notified you a remedy was imposed. On March 17, 2021 the Minnesota Departments 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 March 9, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective February 6, 2021 be discontinued as of March 9, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of January 22, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 6, 2021. 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 February 22, 2021

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

Dear Administrator:

The above facility was surveyed on February 3, 2021 through February 4, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <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.

Re: State Nursing Home Licensing Orders Event ID: V0L411

## The Waterview Woods Llc February 22, 2021 Page 2

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

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

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:

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

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

The Waterview Woods Llc February 22, 2021 Page 3

		& MEDICAID SERVICES				-	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA			INSTRUCTION		E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,				IPLETED
							с
		245277	B. WING				04/2021
NAME OF F	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	•	
		6		601 GF	RANT AVENUE		
	FERVIEW WOODS LL	C		EVEL	ETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0(	00			
	was completed at y complaint investiga NOT to be in comp Requirements for L	2/4/21, an abbreviated survey our facility to conduct tions. Your facility was found liance with 42 CFR Part 483, ong Term Care Facilities.					
		laint was found to be H5277053C, with a F677, and F686.					
		f correction (POC) will serve f compliance upon the ptance.					
	signature is not req						
F 677	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 for Dependent Residents	F 6	77			3/9/21
	CFR(s): 483.24(a)( §483.24(a)(2) A resout activities of dail services to maintain personal and oral h This REQUIREMEN by:	2) ident who is unable to carry y living receives the necessary n good nutrition, grooming, and ygiene; NT is not met as evidenced			677 ADL assistance		
	review, the facility facility facility	ion, interview, and document ailed to ensure toileting cares are planned for 2 of 2		Im	anediate Corrective Action: esident #2 and #3 were		
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	1	TITLE		(X6) DATE
Electron	ically Signed						03/04/2021

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

DEDADTMENT OF LIEALTH AND LIUMAN CEDVICES

PRINTED: 03/08/2021

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVEI CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039								
	CS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	OIN PLE CONSTRUCTION		0938-0391 SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:		G		PLETED		
		245277	B. WING			C 04/2021		
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	UL/			
	<b>TERVIEW WOODS LL</b>	c		601 GRANT AVENUE				
				EVELETH, MN 55734				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 677	Continued From paresidents (R2, R3) Findings include: R2's Admission Rea R2's diagnoses incl pulmonary disease rheumatica (inflamm muscle pain and sti degeneration (low b physical debility. R2's annual Minimu 12/18/20, indicated no rejection of care assistance of two s and toilet use. R2's always incontinent of incontinent of bowe R2's Care Area Ass incontinence dated received assistance of the need to void, incontinent. R2's C always alert staff of assistance to the to with management of and hygiene. R2's care plan initia incontinent of bladd of bladder at least of directed staff to pro for toileting cares, a toilet every two hou	ge 1 reviewed for toileting cares. cord printed 2/4/21, indicated uded chronic obstructive (COPD), polymyalgia matory disorder that causes ffness), lumbosacral disc back spinal degeneration), and um Data Set (MDS) dated R2 was cognitively intact, had behaviors, required extensive taff for bed mobility, transfers MDS further indicated R2 was of bladder, and was frequently 1. essment (CAA) for urinary 12/31/20, indicated R2 e with toileting and was aware though was frequently AA indicated R2 did not incontinence, required ilet, and required assistance of clothing, incontinent brief, ted 8/25/19, indicated R2 was ler, with a goal to be continent once daily. R2's care plan vide assistance of one staff and encourage R2 to use the rs while awake.	F 67	DEFICIENCY)	ue was need ners: ins oviding ng per th ed this t x 2 is ing. hared input			
		eet dated 1/18/21, indicated ncontinent, required						

Facility ID: 00583

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PRINTED: 03/08/2021

	VIC 0038 0301
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) [	NO. 0938-0391 DATE SURVEY COMPLETED
245277 B. WING	C 02/04/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
THE WATERVIEW WOODS LLC 601 GRANT AVENUE EVELETH, MN 55734	
(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAGID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE 	(X5) COMPLETION DATE
<ul> <li>F 677 Continued From page 2 assistance with toileting, and directed staff to encourage repositioning every two hours.</li> <li>R2's nursing assistant (NA) Kardex and toileting/repositioning documentation sheet dated 2/3/21, indicated R2 required assistance of one staff for repositioning and toileting, but lacked a directive for frequency of repositioning and toileting. R2's NA toileting/the toked a directive for frequency of repositioning documentation sheet for the day shift on 2/3/21, indicated R2 had last been toileted and repositioned at 11:40 a.m. R2's toileting/repositioning documentation sheet for the afternoon/evening shift indicated R2 had last been toileted and repositioned at 11:40 a.m.</li> <li>R2's Tissue Tolerance Observation tool (a tool used to assist in determining an individual's tissue tolerance to persistent pressure without signs of skin breakdown), dated 12/17/20, lacked an analysis or assessment of R2's tissue tolerance while siting.</li> <li>On 2/3/21, at 1:13 p.m. R2 was observed sitting in her room when another resident entered her room, as staff brought her meal tray out of her room. Continuous observations were initiated. At 2:07 p.m. R2's guest exited her room. At 2:18 p.m. R2 was eating an ice cream At 2:22 p.m. staff talked to R2 from the doorway and asked her if she needed anything, but did not ask her about the need to use the toilet. The staff stated she was going home.</li> <li>On 2/3/21, at 3:10 p.m. during continuous observations, R2 turned on her call light, and at 3:11 p.m. licensed practical hurse (LPN)-A</li> </ul>	

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		AND HUMAN SERVICES				F	ORM /	03/08/2021 APPROVED
STATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		3) DATE COMF	0938-0391 E SURVEY PLETED
		245277	B. WING				02/0	) )4/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE WA	TERVIEW WOODS LL	с			01 GRANT AVENUE VELETH, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE		(X5) COMPLETION DATE
F 677	answered her call li nebulizer. LPN-A re and asked her if sh before or after the r she thought she she R2 had remained ir wheelchair through At 3:13 p.m. staff fr with a walker, and L incontinent pad cha The staff toileting a documentation form indicated R2 had la toileting cares comp showed a nursing a recorded on the toil documentation form On 2/3/21, at 3:19 p and stated she gue and repositioned ev R2 was able to shiff enough on her own weight was not off-I pressure. On 2/3/21, at 3:26 p entered R2's room. brief was very wet w On 2/3/21, at 3:32 p repositioning and to 11:40 am. RN-A sta when R2 should be On 2/4/21, at 9:44 a	ight and R2 requested her esponded to R2's requests e wanted to be changed nebulizer. LPN-A then said ould have her nebulizer first. In the same position in her out continuous observations. Therapy entered R2's room LPN-A told her R2 wanted her ange after her nebulizer. Ind repositioning in at the nurse's station list been repositioned and pleted at 11:40 a.m. LPN-A assistant (NA) the toileting time leting and repositioning in. Dom. LPN-A was interviewed issed R2 should be toileted very two hours, and then said ther weight and move around ther weight end move around ther weight from Dom. registered nurse (RN)-A RN-A verified R2's incontinent with urine, but not saturated. Dom. RN-A verified R2's poleting time was recorded at ated she was not aware of e repositioned. a.m. the director of nursing care plan should be followed	F 6	;77				

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	-	AND HUMAN SERVICES					FORM	APPROVED	
			(X2) MUI	TIDI	LE CONSTRUCTION		OMB NO. 0938-0391 (X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	` '					PLETED	
			_				(	C	
		245277	B. WING					04/2021	
NAME OF F	PROVIDER OR SUPPLIER		I	S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	-		
	FERVIEW WOODS LL	c		6	601 GRANT AVENUE				
		6		E	EVELETH, MN 55734				
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC			(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI			COMPLÉTION DATE	
1710		,			DEFICIENCY)				
F 677	Continued From pa	ge 4	F 6	677	,				
		o.m. RN-A stated R2 should be							
		sition and use the bathroom							
		N-A verified R2 was not ileted timely on 2/3/21. RN-A							
		e encouraged every two hours.							
		en let staff know when she							
	needed to use the t	oilet or be changed.							
	On 0/4/04 at 0.50 m								
		o.m. the DON stated her residents to be repositioned							
		and for staff to get help if they							
		plete it timely. The DON							
		have been encouraged to							
		the toilet every two hours, and							
		should look at the last							
		ng times and attend first to the been repositioned and toileted							
	the earliest.	been repositioned and tolleted							
	R3's admission rec	ord dated 2/4/21, indicted R3's							
		Alzheimer's disease,							
		splaced fracture of first cervical							
	vertebra.								
	D210 guartaris MD0	dotod 10/6/20 indicated D2							
		dated 10/6/20, indicated R3 re impairment, had no rejection							
		tally dependent on staff for							
		er, and toileting. R3's MDS							
		3 was always incontinent of							
		and was at risk for pressure							
	ulcers.								
	P3's CAA for uring	y incontinence dated 1/5/21,							
		ed assistance with toileting,							

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PRINTED: 03/08/2021

		AND HUMAN SERVICES				FC	TED: 03/08/2021 DRM APPROVED NO. 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		) DATE SURVEY COMPLETED
		245277	B. WING				C <b>02/04/2021</b>
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	c			01 GRANT AVENUE VELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 677	<ul> <li>was non-verbal, hai and was unable to a</li> <li>R3's care plan initia an activities of daily was totally depended was checked and c as needed.</li> <li>R3's care guide she was incontinent of the required assistance repositioning.</li> <li>R3's nursing assistat toileting/repositioning 2/3/21, indicted R3 staff for bed mobility assist with toileting, lift (mechanical lift). documentation she R3 was toileted and and then not again</li> <li>R3's Braden Scale assess a patient's r ulcer) dated 1/5/21, unable to make need bowel and bladder, anticipated by staff every two hours and further indicated R3 using a Hoyer lift, a breakdown.</li> <li>On 2/3/21, at 12:20 observations, R3 w wheelchair facing the</li> </ul>	d severe cognitive impairment, alert staff the need to void. ated 1/18/21, indicted R3 had / living (ADL) self-care deficit, ent on staff for toileting, and changed every two hours and eet dated 2/2/21, indicated R3 bowel and bladder, and e with toileting, and ant Kardex and ng documentation sheet dated required assistance of one cy, repositioning, two staff , and transferred with a Hoyer . R3's toileting/repositioning et for the day 2/3/21, indicated d repositioned at 11:20 a.m.	F 6	577			

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		AND HUMAN SERVICES				FO	ED: 03/08/2021 RM APPROVED NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) [	DATE SURVEY COMPLETED
		245277	B. WING				C 02/04/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	с			01 GRANT AVENUE VELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 677	At 12:26 p.m., staff breakfast tray. R3 facing the window, 1:23 p.m. R3 remai position, no staff ha staff entered R3's m NA-A and NA-B we NA-A stated they we R3 was to be turned every two hours. N last around 11:00 a toileted at 11:40 a.m to use her call light, for toileting and rep and NA-B entered F changing R3's incoh her. NA-B verified urine, but not satura for potential pressu and verified R3's ha to hips and buttocks buttock, and no ope On 2/3/21, at 3:15 p toileting and reposit the nurse's desk, in 11:20 a.m. on the d two-hour toileting and con 2/3/21, indicated repositioned at 11:4 R3's care plan was The facility policy M Assistance Per Car	excited R3's room with continued to be positioned with back toward the door. At ined sitting in her w/c in same ad entered resident's room. No oom until 3:00 p.m. when re about to enter R3's room. ere going check on R3, and d/repositioned, and toileted IA-B stated R3 was toileted IA-B stated R3 was toileted I.m. and verified R3 was last n. NA-A stated R3 was unable , and was dependent on staff positioning needs. RN-A, NA-A, R3's room and assisted in ntinent brief, and repositioned R3's brief was incontinent of ated. RN-A assessed R3's skin are related skin impairments, ad self-inflicted escorted areas s, blanchable redness to en areas. D.m. RN-A verified R3's tioning documentation sheet at idicated R3 was toileted last at lay shift, and R3 was over the nd repositioning schedule. a.m. the DON verified R3's bileting documentation sheet d R3 was toileted and 40 a.m. and 3:15 p.m. and not being followed. Monarch HealthCare ADL re Plan revised date 5/18, t residents will be checked and	F 6	;77			

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	ARE & MEDICAID SERVICES				0938-039
TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COM	E SURVEY IPLETED
	245277	B. WING _			C 04/2021
NAME OF PROVIDER OR SUPP	IER		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WATERVIEW WOOD	SLLC		601 GRANT AVENUE EVELETH, MN 55734		
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIOI DATE
F 686 Treatment/Svc SS=D CFR(s): 483.25	s to Prevent/Heal Pressure Ulcer (b)(1)(i)(ii)	F 68	36		3/9/21
Based on the c resident, the fa(i) A resident re professional st pressure ulcers ulcers unless ti demonstrates f(ii) A resident w necessary treat with profession promote healin new ulcers from This REQUIRE by: Based on obso review the facil and off-loading in the plan of c pressure ulcers reviewed for prFindings include Pressure injury Pressure lnjury A pressure injury and/or underlyi prominence or device. The inj open ulcer and as a result of in	Pressure ulcers. omprehensive assessment of a cility must ensure that- ceives care, consistent with andards of practice, to prevent and does not develop pressure he individual's clinical condition that they were unavoidable; and ith pressure ulcers receives ment and services, consistent al standards of practice, to g, prevent infection and prevent in developing. MENT is not met as evidenced ervation, interview and document ty failed to ensure repositioning was timely completed as directed are to prevent development of for 2 of 3 residents (R2, R3), essure ulcers. e: stages defined by the National Advisory Panel (NPUAP):		F686 Treatment to Prevent/Treat Pressure Ulcers Immediate Corrective Action: Resident #2 and #3 were toileted/repositioned as soon as identified. Skin check was comp no new concerns noted. NARs at to these residents were re-educat the need to provide these servic Corrective Action as it applies to The Policy and Procedure on Sk Assessment and Wound Manag was reviewed and remains curre All nurses, TMAs, and NARs we re-educated on 3/5/21 on the Sk Assessment and Wound Manag Policy specifically providing assis with toileting/repositioning per re individualized care pan.	issue was leted with ssigned ated on es timely. others: in ement ent. re in ement stance sident	

Facility ID: 00583

If continuation sheet Page 8 of 17

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY
IND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i		C
		245277	B. WING			04/2021
NAME OF F	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
THE WAT	ERVIEW WOODS LL	c		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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 686	erythema of intact s Intact skin with a lo erythema, which m pigmented skin. Pre erythema or change or firmness may pre changes do not ince discoloration; these pressure injury. Stage 2 Pressure In loss with exposed of Partial-thickness lo dermis. The wound moist, and may alse ruptured serum-fille visible and deeper Granulation tissue, present. These inju- adverse microclima the pelvis and sheat should not be used associated skin data incontinence associated skin data	njury: Non-blanchable skin calized area of non-blanchable ay appear differently in darkly esence of blanchable es in sensation, temperature, ecede visual changes. Color lude purple or maroon e may indicate deep tissue njury: Partial-thickness skin dermis ss of skin with exposed I bed is viable, pink or red, o present as an intact or ed blister. Adipose (fat) is not tissues are not visible. slough and eschar are not irries commonly result from ate and shear in the skin over ar in the heel. This stage to describe moisture mage (MASD) including ciated dermatitis (IAD), atitis (ITD), medical adhesive MARSI), or traumatic wounds	F 686	toileting/repositioning will be pr assistance per care plan/care details. Date of Compliance: 3/9/21 Recurrence will be prevented I Audits of 5 random residents w completed weekly x 4 then mo months to assure timely assist provided for toileting and repos The results of these audits will with the facility QAPI committe on the need to increase, decre discontinue the audits. Corrections will be monitored I DON/Nurse Managers/Design	sheet by: will be onthly x 2 tance is sitioning. I be shared be for input ease or by:	
	R2's diagnoses inc pulmonary disease polymyalgia rheum that causes muscle	ord dated 2/4/21, indicated luded chronic obstructive (COPD), muscle weakness, atica (inflammatory disorder pain and stiffness), egeneration (low back spinal physical debility.				

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		AND HUMAN SERVICES					FORM	03/08/2021 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245277	B. WING					C 04/2021
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	Ξ		
THE WA	TERVIEW WOODS LL	c			11 GRANT AVENUE VELETH, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD E		(X5) COMPLETION DATE
F 686	no rejection of care assistance of two s and toilet use. R2's was always incontir incontinent of bowe ulcers, and had no R2's Care Area Ass ulcers dated 12/31/ risk for pressure ulc Scale (a tool used t the risk for pressure pressure ulcers. R2's care plan initia being at risk for skin mobility, being chai blister on her right h direction for frequent edited on 2/3/21, to hours." R2's care p 9/30/19, directed st toilet every two hou elimination needs a R2's care guide she R2 was frequently i assistance with toile encourage reposition R2's nursing assista toileting/repositionir 2/3/21, indicated R2 staff for repositionir directive for frequent toileting. R2's NA to documentation she	behaviors, required extensive taff for bed mobility, transfers a MDS further indicated R2 nent of bladder, frequently d, was at risk for pressure unhealed pressure ulcers. eessment (CAA) for pressure 20, indicated R2 was at low cers according the Braden to assist with determination of e ulcer development), had no ated 7/1/19, identified R2 as n breakdown related to limited rfast, and indicated R2 had a neel. R2's care plan lacked ncy of repositioning, but was direct to "encourage every 2 blan intervention initiated aff to encourage R2 to use the rs while awake, and assess and check every two hours. eet dated 1/18/21, indicated ncontinent and required eting, and directed staff to bring every two hours. ant (NA) Kardex and ng documentation sheet dated 2 required assistance of one ng and toileting, but lacked a ncy of repositioning and bileting/repositioning et for the day shift on 2/3/21, st been toileted and	F	\$86				

Facility ID: 00583

If continuation sheet Page 10 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ST CONNECTION	IDENTIFICATION NONDER.	A. BUILD	ING	3		C
		245277	B. WING	-		02/	04/2021
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 601 GRANT AVENUE		
THE WA	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		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 686	toileting/repositionir afternoon/evening s been toileted and re R2's Tissue Tolerar used to assist in de tolerance to persist skin breakdown), da analysis or assess while sitting. R2's Weekly Skin In indicated R2 had a thigh near the groin rubbing, and rednes navel, though had r concerns at that tim R2's Progress note had new orders to b nurse. R2's initial wound c progress note dated fluid-filled right heel presented as a fluid 2.5 centimeters (cm recommendations i protectant, the facil heel off-loading pro R2's Braden Scale	And the second s	Fθ	386			

If continuation sheet Page 11 of 17

PRINTED: 03/08/2021

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	03/08/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	0	(X3) DATE COM	E SURVEY PLETED
		245277	B. WING _					C 04/2021
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP	CODE		
THE WAT	FERVIEW WOODS LL	с			11 GRANT AVENUE VELETH, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD	BE	(X5) COMPLETION DATE
F 686	Continued From pa pressure ulcers.	ge 11	F 68	36				
	1/28/21, indicated F a pressure ulcer, pr to the right heel me wound care NP pro implementation of t	P progress notes dated R2 was seen for evaluation of resenting as a dry firm callus asuring 2.5 x 1 cm. R2's gress note recommended he pressure ulcer prevention ff-loading per the facility						
	in her room when a room, as staff broug room. Continuous of 2:07 p.m. R2's gue p.m. R2 was eating been delivered to h room to room, deliv staff talked to her fr her if she needed a about the need to u	o.m. R2 was observed sitting nother resident entered her ght her meal tray out of her observations were initiated. At est exited her room. At 2:18 g an ice cream cone that had er by staff who were going ering ice cream. At 2:22 p.m. om the doorway and asked nything, but did not ask her se the toilet or encourage her oad. The staff stated she was						
	observations, R2 tu 3:11 p.m. licensed p answered her call li nebulizer. LPN-A re asked her if she wa after the nebulizer. she should have he remained in the sar throughout continue At 3:13 p.m. staff fr with a walker, and L	b.m. during continuous rned on her call light, and at practical nurse (LPN)-A ght and R2 requested her isponded to R2's requests and inted to be changed before or LPN-A then said she thought or nebulizer first. R2 had ne position in her wheelchair bus observations. om therapy entered R2's room LPN-A told her R2 wanted an inge after her nebulizer.						

If continuation sheet Page 12 of 17

		AND HUMAN SERVICES					FORM	03/08/2021 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	0	(X3) DATI COM	0938-0391 E SURVEY PLETED
		245277	B. WING					C 04/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP C	ODE		
THE WA	TERVIEW WOODS LL	c			01 GRANT AVENUE VELETH, 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 686	The staff toileting a documentation form indicated R2 had la toileting cares comp showed a nursing a recorded on the toil documentation form On 2/3/21, at 3:19 p guessed R2 should every two hours, an shift her weight and own. LPN-A verifie off-loading for relief On 2/3/21, at 3:26 p entered R2's room for potential pressu R2 stated she was incontinent brief wa R2's bottom for pre had blanchable (ski pressure) redness, verified R2's inconti not saturated. On 2/3/21, at 3:32 p repositioning and to 11:40 am. RN-A sta what R2's reposition On 2/4/21, at 9:44 a (DON) verified shift and stated off-loadi seconds to relieve of stated R2's care pla repositioning and to	nd repositioning n at the nurse's station st been repositioned and pleted at 11:40 a.m. LPN-A assistant (NA) the toileting time leting and repositioning n. Dom. LPN-A stated she be toileted and repositioned ad then said R2 was able to a move around enough on her d shifting her weight was not from pressure. Dom. registered nurse (RN)-A to look at R2's skin to inspect re-related skin impairments. wet. R2 was assisted to stand, is removed and RN-A viewed ssure areas. RN-A verified R2 in color returned after relief of and no open areas. RN-A inent brief was very wet, but Dom. RN-A verified R2's bileting time was recorded at ated she was not aware of ning time was. a.m. the director of nursing ing weight was not off-loading ng should be at least 60 effects of pressure. The DON an should be followed for	F6	86				

Facility ID: 00583

If continuation sheet Page 13 of 17

	-	AND HUMAN SERVICES				FORM	. 03/08/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	PLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	3	COMPLETED	
		245277	B. WING				04/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THE WAT	THE WATERVIEW WOODS LLC				601 GRANT AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	she sees R2 weekly heel. On 2/4/21, at 2:42 p seen by wound card heel. RN-A reviewe pressure ulcers, an encouraged to repo- bathroom every two not repositioned an RN-A stated R2 sho hours. RN-A stated she needed to use On 2/4/21, at 2:58 p expectation was for and toileted timely, were unable to com- verified R2 should h reposition every two shift should look at times and attend fir	ge 13 y to do wound care on R2's o.m. RN-A stated R2 was e nurse for a blister on her d R2's interventions to prevent d stated R2 should be obsition and to use the o hours. RN-A verified R2 was d toileted timely on 2/3/21. ould be repositioned every two R2 often let staff know when the toilet or be changed.	F 6	\$86	5		
	diagnoses included	ord dated 2/4/21, indicted R3's Alzheimer's disease, splaced fracture of first cervical					
	had severe cognitiv care, was total depe	e dated 10/6/20, indicated R3 re impairment, no rejection of endent on staff for bed and toileting. R3's MDS					

If continuation sheet Page 14 of 17

PRINTED: 03/08/2021

		AND HUMAN SERVICES				FORM	: 03/08/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245277	B. WING	÷			C / <b>04/2021</b>
NAME OF	PROVIDER OR SUPPLIER	L	1	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	с			601 GRANT AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 686		-	F	686	;		
		3 was always incontinent of and was at risk for pressure					
	indicated R3 was a	ure ulcers dated 1/5/21, t risk for development of cording the Braden Scale, and cers.					
	at risk for skin brea	ated 9/26/19, indicted R3 was kdown related to impaired ed staff to turn and reposition and as needed.					
	was incontinent of t	eet dated 2/2/21, indicated R3 bowel and bladder, required eting, and repositioning.					
	2/3/21, indicted R3 staff for bed mobilit assist with toileting, lift (mechanical lift). documentation she	ng documentation sheet dated required assistance of one y, repositioning, two staff , and transferred with a Hoyer . R3's toileting/repositioning et for the day 2/3/21, indicated d repositioned at 11:20 a.m.					
	and 2/3/21, indicate needs known, was bladder, and R3 ne by checking and ch as needed. Assess	assessments dated 1/5/21, ed R3 was unable to make incontinent of bowel and eds were anticipated by staff anging every two hours and ment further indicated R3 was ed using a Hoyer lift, and was breakdown.					
		nfection dated 1/26/21, cratches to upper thighs and					

If continuation sheet Page 15 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/08/2021 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	3		PLETED
		245277	B. WING				C 04/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•=	
THE WAT	ERVIEW WOODS LL	с			601 GRANT AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	calves from resident issues noted. On 2/3/21, at 12:20 observed. R3 was s room facing the win while, staff was ass 12:26 p.m. staff exc breakfast tray. R3 of facing the window, y staff entered R3's ro NA-A and NA-B wei NA-A and NA-B wei NA-A stated they we R3 was to be turned every two hours. N last around 11:00 a repositioned at 11:4 unable to use her c on staff for toileting On 2/3/21, at 3:07 p entered R3's room repositioning and in brief. NA-B verified urine, but not satura skin for potential pro- impairments, and ve escorted areas to h redness to buttock, On 2/3/21, at 3:15 p toileting and reposit the nurse's desk, in 11:20 a.m. on the d two-hour toileting at On 2/4/21, at 9:44 at	p.m. R3 was continuously sitting in a wheelchair in her dow, back toward the door isting R3 with breakfast. At cited R3's room with her continued to be positioned with back toward the door. No oom until 3:00 p.m. when re about to enter R3's room. ere going check on R3, and d/repositioned, and toileted A-B stated R3 was toileted .m. and verified R3's was last 0 a.m. NA-A stated R3 was all light, and was dependent and repositioning needs. b.m. RN-A, NA-A, and NA-B and assisted with o changing R3's incontinent I R3's brief was incontinent of ated. RN-A assessed R3's essure related skin erified R3's had self-inflicted ips and buttocks, blanchable and no open areas. b.m. RN-A verified R3's tioning documentation sheet at dicated R3 was toileted last at ay shift, and R3 was over the nd repositioning schedule. a.m. the DON verified R3's	F6	\$86			
		tioning documentation sheet I R3 was toileted and					

PRINTED: 03/08/2021

		AND HUMAN SERVICES				FORM	03/08/2021 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION			E SURVEY PLETED
		245277	B. WING				, )4/2021
NAME OF	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE,	ZIP CODE		
THE WA	TERVIEW WOODS LL	c		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 PREFI> TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
F 686	repositioned at 11:4 R3's care plan was The facility policy S Management date will be reviewed an annually and upon Tissue tolerance of completed on admi upon significant cha pressure related sk perform routine ski nurses will be notifi	age 16 40 a.m. and 3:15 p.m. and not being followed. 5kin Assessment and Wound 7/18, directed Braden Scales d completed quarterly, significant change in condition. Deservation and evaluation was assion/re-admission, annually, ange and with development of tin impairment. Staff will n inspections with daily cares, ed of skin changes and weekly be competed by licensed staff.	F 6				

Facility ID: 00583

If continuation sheet Page 17 of 17



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 22, 2021

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

Dear Administrator:

The above facility was surveyed on February 3, 2021 through February 4, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <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.

Re: State Nursing Home Licensing Orders Event ID: V0L411

## The Waterview Woods Llc February 22, 2021 Page 2

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

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

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:

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

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

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY PLETED
		00583	B. WING			C )4/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	TERVIEW WOODS LL	601 GRAM	NT 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	was conducted to d State Licensure. Yo NOT in compliance Please indicate in y correction that you and identify the date	TS: 2/4/21, an abbreviated survey letermine compliance with our facility was found to be with the MN State Licensure. Your electronic plan of have reviewed these orders, e when they will be completed.				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 03/04/21

Electronically Signed

STATE FORM

6899

If continuation sheet 1 of 20

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00583	B. WING			04/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	TERVIEW WOODS LL	C	NT AVENUE I, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED:	The following complaint was found to be SUBSTANTIATED: H5277053C with a licensing order issued at S0840, and S0900.				
	the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state sta listed in the "Summ column and replace the correction order the findings which a statute after the sta as evidence by." For	nent of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for ne assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met ollowing the surveyors findings Method of Correction and rection.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si obul.htm. The State delineated on the a Department of Hea you electronically. is necessary for State enter the word "CO available for text. Ye electronic State lice heading completion	in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf clicensing orders are				
	the Minnesota Depa is enrolled in ePOC	artment of Health. The facility and therefore a signature is bottom of the first page of				

Minnesota Department of Health STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00583	B. WING			C 04/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	TERVIEW WOODS LL	C	NT AVENUE H, MN 55734			
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI	ON SHOULD BE	(X5) COMPLET
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TO DEFICIENCY		DATE
2 000	Continued From pa	ge 2	2 000			
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	NRD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 840	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 2 B Adequate and re; Clean skin	2 840			3/9/21
		or determining adequate and criteria for determining er care include:				
	odors. A bathing pl resident's plan of ca condition requires t must be given a co other day and more incontinent resident every two hours, an	and freedom from offensive an must be part of each are. A resident whose hat the resident remain in bed mplete bath at least every e often as indicated. An t must be checked at least ad must receive perineal care ode of incontinence.				
	Notwithstanding Mi 4658.0520, an inco checked according written in the reside attending physician interval longer than if competent, or a fa appointed conserva agent of a resident in writing to waive p determining this int	1. Incontinent residents. nnesota Rules, part ntinent resident must be to a specific time interval ent's care plan. The resident's must authorize in writing any two hours unless the resident amily member or legally ator, guardian, or health care who is not competent, agrees obysician involvement in erval, and this waiver is resident's care plan. ]	,			
		hing must be provided the bed or clothing is soiled.				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY DMPLETED
		00583	B. WING	c	2/04/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	
THE WA	TERVIEW WOODS LL	C	IT AVENUE , 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 840	Continued From pa	ige 3	2 840		
	the perineal area. It to keep the bed dry comfort. Special at skin to prevent irrita types of protectors completely covered contact with the res	des the washing and drying of Pads or diapers must be used and for the resident's ttention must be given to the ation. Rubber, plastic, or other must be kept clean, be I, and not come in direct sident. Soiled linen and moved immediately from revent odors.			
	by: Based on observati review, the facility f were provided as c	ent is not met as evidenced ion, interview, and document ailed to ensure toileting cares are planned for 2 of 2 reviewed for toileting cares.		F677 ADL assistance Immediate Corrective Action: Resident #2 and #3 were toileted/repositioned as soon as issue w identified. NARs assigned to these residents were re-educated on the need	
	R2's diagnoses incl pulmonary disease rheumatica (inflami muscle pain and st	cord printed 2/4/21, indicated luded chronic obstructive (COPD), polymyalgia matory disorder that causes iffness), lumbosacral disc back spinal degeneration), and		provide these services timely. Corrective Action as it applies to others: The Policy and Procedure on ADL assistance was reviewed and remains current. All nurses, TMAs, and NARs were re-educated on 3/5/21 on the ADL assistance Policy which includes provide assistance with toileting/repositioning pe	ng
	12/18/20, indicated no rejection of care assistance of two s and toilet use. R2's	um Data Set (MDS) dated R2 was cognitively intact, had behaviors, required extensive taff for bed mobility, transfers MDS further indicated R2 was of bladder, and was frequently		resident individualized care pan. All residents needing assistance with toileting/repositioning will be provided th assistance per care plan/care sheet details. Date of Compliance: 3/9/21 Recurrence will be prevented by: Audits of 5 random residents will be	
		essment (CAA) for urinary 12/31/20, indicated R2		completed weekly x 4 then monthly x 2 months to assure timely assistance is	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SL COMPLE	
		00583	B. WING			4/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
THE WAT	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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 840	of the need to void, incontinent. R2's C always alert staff of assistance to the to with management of and hygiene. R2's care plan initial incontinent of bladd of bladder at least of directed staff to pro for toileting cares, a toilet every two hou R2's care guide she R2 was frequently in assistance with toile encourage reposition R2's nursing assista toileting/repositionin 2/3/21, indicated R2 staff for repositionin directive for frequent toileting. R2's NA to documentation she indicated R2 had la repositioned at 11:4 toileting/repositionin afternoon/evening s been toileted and reposition	e with toileting and was aware though was frequently AA indicated R2 did not incontinence, required ilet, and required assistance of clothing, incontinent brief, ted 8/25/19, indicated R2 was ler, with a goal to be continent once daily. R2's care plan vide assistance of one staff and encourage R2 to use the rs while awake. eet dated 1/18/21, indicated ncontinent, required eting, and directed staff to oning every two hours. ant (NA) Kardex and ng documentation sheet dated 2 required assistance of one ng and toileting, but lacked a ncy of repositioning and oileting/repositioning et for the day shift on 2/3/21, st been toileted and	2 840	provided for toileting and rep The results of these audits v with the facility QAPI commi on the need to increase, ded discontinue the audits. Corrections will be monitore DON/Nurse Managers/Desig	vill be shared ttee for input crease or d by:	
	used to assist in de tolerance to persist skin breakdown), da	termining an individual's tissue ent pressure without signs of ated 12/17/20, lacked an nent of R2's tissue tolerance				

If continuation sheet 5 of 20

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00583	B. WING		02/	04/2021
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	С	NT AVENUE H, 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 ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 840	in her room when a room, as staff broug room. Continuous 2:07 p.m. R2's gue p.m. R2 was eating been delivered to h room to room, deliv staff talked to R2 fm her if she needed a about the need to u she was going hom On 2/3/21, at 3:10 p observations, R2 to 3:11 p.m. licensed p answered her call li nebulizer. LPN-A ro and asked her if sh before or after the r she thought she sh R2 had remained ir wheelchair through At 3:13 p.m. staff fm with a walker, and L incontinent pad cha The staff toileting a documentation form indicated R2 had la toileting cares comp showed a nursing a recorded on the toil documentation form On 2/3/21, at 3:19 p and stated she gue and repositioned ev	<ul> <li>b.m. R2 was observed sitting inother resident entered her ght her meal tray out of her observations were initiated. At est exited her room. At 2:18 g an ice cream cone that had er by staff who were going rering ice cream. At 2:22 p.m. om the doorway and asked inything, but did not ask her ise the toilet. The staff stated ie.</li> <li>b.m. during continuous urned on her call light, and at practical nurse (LPN)-A ight and R2 requested her esponded to R2's requests e wanted to be changed nebulizer. LPN-A then said ould have her nebulizer first. In the same position in her out continuous observations. om therapy entered R2's room _PN-A told her R2 wanted her ange after her nebulizer.</li> <li>nd repositioning in at the nurse's station st been repositioned and pleted at 11:40 a.m. LPN-A assistant (NA) the toileting time leting and repositioning</li> </ul>				

	NT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00583	B. WING		02/	04/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	C	NT AVENUE H, MN 55734			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 840	Continued From pa	ge 6	2 840			
	weight was not off-l pressure.	oading for relief from				
	entered R2's room.	o.m. registered nurse (RN)-A RN-A verified R2's incontinent vith urine, but not saturated.	t			
	repositioning and to	o.m. RN-A verified R2's ileting time was recorded at ated she was not aware of repositioned.				
		a.m. the director of nursing care plan should be followed d toileting.				
	encouraged to repo every two hours. R repositioned and to stated R2 should be RN-A stated R2 ofte	o.m. RN-A stated R2 should be sition and use the bathroom N-A verified R2 was not ileted timely on 2/3/21. RN-A e encouraged every two hours en let staff know when she oilet or be changed.				
	expectation was for and toileted timely, were unable to com verified R2 should h reposition and use to the afternoon shift s toileting/repositionin	b.m. the DON stated her residents to be repositioned and for staff to get help if they plete it timely. The DON have been encouraged to the toilet every two hours, and should look at the last ag times and attend first to the been repositioned and toileted				
	diagnoses included	ord dated 2/4/21, indicted R3's Alzheimer's disease, placed fracture of first cervica				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00583			(X3) DATE SURVEY COMPLETED C 02/04/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	1	•
	TERVIEW WOODS LL	C 601 GRAI	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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 840	R3's quarterly MDS had severe cognitiv of care, and was to bed mobility, transfe further indicated R3 bowel and bladder, ulcers. R3's CAA for urinar indicated R3 receive was non-verbal, had and was unable to a R3's care plan initia an activities of daily was totally depende was checked and c as needed. R3's care guide she was incontinent of k required assistance repositioning. R3's nursing assista toileting/repositionir 2/3/21, indicted R3 staff for bed mobility assist with toileting, lift (mechanical lift). documentation she R3 was toileted and and then not again R3's Braden Scale assess a patient's r ulcer) dated 1/5/21, unable to make nee	dated 10/6/20, indicated R3 re impairment, had no rejection tally dependent on staff for er, and toileting. R3's MDS was always incontinent of and was at risk for pressure y incontinence dated 1/5/21, ed assistance with toileting, d severe cognitive impairment, alert staff the need to void. ted 1/18/21, indicted R3 had v living (ADL) self-care deficit, ent on staff for toileting, and hanged every two hours and eet dated 2/2/21, indicated R3 powel and bladder, and e with toileting, and ant Kardex and ng documentation sheet dated required assistance of one y, repositioning, two staff and transferred with a Hoyer R3's toileting/repositioning et for the day 2/3/21, indicated I repositioned at 11:20 a.m.	2 840			

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C	
		00583	B. WING			02/04/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
	FERVIEW WOODS LL	С	NT AVENUE H, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 840	Continued From pa	age 8	2 840				
	every two hours and as needed. Assessment further indicated R3 was chair fast, transferred using a Hoyer lift, and was at mild risk for skin breakdown.						
	observations, R3 w wheelchair facing t door while staff was At 12:26 p.m., staff breakfast tray. R3 facing the window, 1:23 p.m. R3 rema position, no staff ha staff entered R3's r NA-A and NA-B we NA-A stated they w R3 was to be turne every two hours. N last around 11:00 a toileted at 11:40 a.r to use her call light for toileting and rep and NA-B entered changing R3's inco her. NA-B verified urine, but not satur for potential pressu and verified R3's ha	b p.m. during continous vas sitting in her room in her he window, back toward the s assisting R3 with breakfast. excited R3's room with continued to be positioned with back toward the door. At ined sitting in her w/c in same ad entered resident's room. No room until 3:00 p.m. when ere about to enter R3's room. Were going check on R3, and d/repositioned, and toileted IA-B stated R3 was toileted IA-B stated R3 was toileted I.m. and verified R3 was last m. NA-A stated R3 was unable , and was dependent on staff positioning needs. RN-A, NA-A R3's room and assisted in intinent brief, and repositioned R3's brief was incontinent of ated. RN-A assessed R3's skir ure related skin impairments, ad self-inflicted escorted areas is, blanchable redness to en areas.	n				
	toileting and reposi the nurse's desk, ir 11:20 a.m. on the c	p.m. RN-A verified R3's tioning documentation sheet a ndicated R3 was toileted last at lay shift, and R3 was over the and repositioning schedule.					
		a.m. the DON verified R3's bileting documentation sheet					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00583	B. WING			02/04/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
HE WAT	ERVIEW WOODS LL	С	NT AVENUE H, 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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 840	Continued From pa	ge 9	2 840				
		l R3 was toileted and 0 a.m. and 3:15 p.m. and not being followed.					
	Assistance Per Car	lonarch HealthCare ADL e Plan revised date 5/18, t residents will be checked and o care plan.	ł				
	The Director of Nur develop, review, an procedures to ensu appropriate toileting breakdown and infe The DON or design appropriate staff on The DON or design	HOD OF CORRECTION: sing (DON) or designee could d/or revise policies and re residents receive g cares to prevent skin ections and maintain dignity. ee could educate all the policies and procedures. ee could develop monitoring ongoing compliance.					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one	)				
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			3/9/21	
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which					
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and					
	B. a resident w	ho has pressure sores					

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		TE SURVEY MPLETED	
		00583	B. WING	02	C 02/04/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
		601 GRAM	NT AVENUE			
THE WA	TERVIEW WOODS LL	C EVELETH	, MN 55734	L		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET DATE	
IAO			IAO	DEFICIENCY)		
2 900	Continued From pa	age 10	2 900			
		-				
		y treatment and services to				
		revent infection, and prevent				
	new sores from dev	veloping.				
	This MN Requirem	ent is not met as evidenced				
	by:					
	2	ion, interview and document		F686 Treatment to Prevent/Treat Pressu	re	
		ailed to ensure repositioning		Ulcers		
		s timely completed as directed		Immediate Corrective Action:		
		to prevent development of		Resident #2 and #3 were		
	pressure ulcers for	2 of 3 residents (R2, R3),		toileted/repositioned as soon as issue wa	IS	
	reviewed for pressu	ure ulcers.		identified. Skin check was completed with	า	
				no new concerns noted. NARs assigned	to	
	Findings include:			these residents were re-educated on the		
				need to provide these services timely.		
		ges defined by the National		Corrective Action as it applies to others:		
	Pressure Ulcer Adv	visory Panel (NPUAP):		The Policy and Procedure on Skin		
	Dressure Injun <i>u</i>			Assessment and Wound Management was reviewed and remains current.		
	Pressure Injury:	localized demoge to the skip				
		localized damage to the skin oft tissue usually over a bony		All nurses, TMAs, and NARs were re-educated on 3/5/21 on the Skin		
		ted to a medical or other		Assessment and Wound Management		
		can present as intact skin or an		Policy specifically providing assistance		
		y be painful. The injury occurs		with toileting/repositioning per resident		
		se and/or prolonged pressure		individualized care pan.		
	or pressure in com					
				All residents needing assistance with		
	Stage 1 Pressure In	njury: Non-blanchable		toileting/repositioning will be provided this	6	
	erythema of intact s			assistance per care plan/care sheet		
	Intact skin with a lo	calized area of non-blanchable		details.		
		ay appear differently in darkly		Date of Compliance: 3/9/21		
		esence of blanchable		Recurrence will be prevented by:		
		es in sensation, temperature,		Audits of 5 random residents will be		
		ecede visual changes. Color		completed weekly x 4 then monthly x 2		
		lude purple or maroon		months to assure timely assistance is		
		e may indicate deep tissue		provided for toileting and repositioning.		
	pressure injury.			The results of these audits will be shared		
	Otomo O Desserver la	niumu Deutiel Abielus		with the facility QAPI committee for input		
	Stage 2 Pressure II	njury: Partial-thickness skin		on the need to increase, decrease or		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	E CONSTRUCTION	COMI	E SURVEY PLETED C	
		00583	B. WING	02		2/04/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
	FERVIEW WOODS LL	C	NT AVENUE H, MN 55734	L			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
2 900	Continued From pa	age 11	2 900				
	2 900 Continued From page 11 loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).			discontinue the audits. Corrections will be monitore DON/Nurse Managers/Desig			
	R2's diagnoses inc pulmonary disease polymyalgia rheum that causes muscle	ord dated 2/4/21, indicated luded chronic obstructive (COPD), muscle weakness, atica (inflammatory disorder e pain and stiffness), egeneration (low back spinal physical debility.					
	12/18/20, indicated no rejection of care assistance of two s and toilet use. R2's was always incontin incontinent of bowe	um Data Set (MDS) dated R2 was cognitively intact, had behaviors, required extensive staff for bed mobility, transfers s MDS further indicated R2 nent of bladder, frequently el, was at risk for pressure unhealed pressure ulcers.					
	ulcers dated 12/31/ risk for pressure ul Scale (a tool used	sessment (CAA) for pressure /20, indicated R2 was at low cers according the Braden to assist with determination of e ulcer development), had no					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00583	B. WING			04/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	С	NT AVENUE H, MN 55734			
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	DATE
2 900	Continued From pa	ge 12	2 900			
	being at risk for skii mobility, being chai blister on her right h direction for frequer edited on 2/3/21, to hours." R2's care p 9/30/19, directed st toilet every two hou elimination needs a R2's care guide she R2 was frequently i assistance with toile	ated 7/1/19, identified R2 as n breakdown related to limited rfast, and indicated R2 had a neel. R2's care plan lacked ney of repositioning, but was direct to "encourage every 2 olan intervention initiated aff to encourage R2 to use the rs while awake, and assess and check every two hours. eet dated 1/18/21, indicated ncontinent and required eting, and directed staff to oning every two hours.				
	toileting/repositionir 2/3/21, indicated R2 staff for repositionir directive for frequer toileting. R2's NA to documentation she indicated R2 had la repositioned at 11:4 toileting/repositionir afternoon/evening s been toileted and re	ng documentation sheet for the shift indicated R2 had last epositioned at 11:40 a.m.				
	used to assist in de tolerance to persist skin breakdown), da	nce Observation tool (a tool termining an individual's tissue ent pressure without signs of ated 12/17/20, lacked an nent of R2's tissue tolerance	9			
	R2's Weekly Skin Ir indicated R2 had no	nspection dated 12/28/20, o pressure ulcers.				

Minnesc	ta Department of He	alth				APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00583	B. WING		C 02/04/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
		601 GRA	NT AVENUE			
	TERVIEW WOODS LL	EVELETI	H, 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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 13	2 900			
	R2's Weekly Skin Ir indicated R2 had a thigh near the groin rubbing, and rednes navel, though had r concerns at that tim R2's Progress note had new orders to b nurse. R2's initial wound c progress note dated fluid-filled right heel presented as a fluid 2.5 centimeters (cm recommendations i	hspection dated 1/4/21, small open area on the upper area where the brief was ss on thighs and around her no other skin issues or ne. s dated 1/13/21, indicated R2 be seen by a wound care are nurse practitioner (NP) d 1/14/21, indicated R2 had a Stage 2 pressure ulcer that d-filled blister and measured n) by 1 cm. R2's treatment ncluded a heel boot				
	heel off-loading pro	s dated 1/26/21, indicated R2				
	R2's Braden Scale	assessments dated 1/25/21 ed R2 was at low risk for				
	1/28/21, indicated F a pressure ulcer, pr to the right heel me wound care NP pro implementation of t	P progress notes dated R2 was seen for evaluation of resenting as a dry firm callus asuring 2.5 x 1 cm. R2's gress note recommended he pressure ulcer prevention ff-loading per the facility				
	in her room when a room, as staff broug	o.m. R2 was observed sitting nother resident entered her ght her meal tray out of her observations were initiated. At				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/04/2021				
		00583	B. WING						
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE					
THE WATERVIEW WOODS LLC 601 GRANT AVENUE EVELETH, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE			
	p.m. R2 was eating been delivered to h room to room, deliv staff talked to her fr her if she needed a about the need to u to reposition or off-l going home. On 2/3/21, at 3:10 p	est exited her room. At 2:18 g an ice cream cone that had er by staff who were going ering ice cream. At 2:22 p.m. room the doorway and asked nything, but did not ask her se the toilet or encourage her oad. The staff stated she was							
	3:11 p.m. licensed p answered her call li nebulizer. LPN-A re asked her if she wa after the nebulizer. she should have he remained in the sar throughout continue At 3:13 p.m. staff fr with a walker, and I	rned on her call light, and at practical nurse (LPN)-A ght and R2 requested her sponded to R2's requests and inted to be changed before or LPN-A then said she thought renebulizer first. R2 had ne position in her wheelchair bus observations. om therapy entered R2's room LPN-A told her R2 wanted an inge after her nebulizer.							
	indicated R2 had la toileting cares com showed a nursing a	n at the nurse's station st been repositioned and oleted at 11:40 a.m. LPN-A issistant (NA) the toileting time eting and repositioning	9						
	guessed R2 should every two hours, ar shift her weight and	b.m. LPN-A stated she be toileted and repositioned of then said R2 was able to move around enough on her d shifting her weight was not from pressure.							

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00583		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/04/2021	
					02/	04/2021
NAIVIE OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST . <b>NT AVENUE</b>	ATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	С	H, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ige 15	2 900			
	for potential pressu R2 stated she was incontinent brief wa R2's bottom for pre had blanchable (sk pressure) redness, verified R2's incont not saturated. On 2/3/21, at 3:32 p repositioning and to 11:40 am. RN-A st what R2's repositio On 2/4/21, at 9:44 a (DON) verified shift and stated off-loadi seconds to relieve of	to look at R2's skin to inspect re-related skin impairments. wet. R2 was assisted to stand is removed and RN-A viewed issure areas. RN-A verified R2 in color returned after relief of and no open areas. RN-A inent brief was very wet, but o.m. RN-A verified R2's bileting time was recorded at ated she was not aware of ning time was. a.m. the director of nursing ting weight was not off-loading ing should be at least 60 effects of pressure. The DON an should be followed for				
		pileting. p.m. wound care NP stated y to do wound care on R2's				
	seen by wound car heel. RN-A reviewe pressure ulcers, an encouraged to repo bathroom every two not repositioned an RN-A stated R2 sho hours. RN-A stated	o.m. RN-A stated R2 was e nurse for a blister on her d R2's interventions to prevent d stated R2 should be osition and to use the o hours. RN-A verified R2 was d toileted timely on 2/3/21. ould be repositioned every two R2 often let staff know when the toilet or be changed.				
	expectation was for	o.m. the DON stated her r residents to be repositioned and for staff to get help if they				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/04/2021	
		00583	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	С	NT AVENUE H, MN 55734			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO TDEFICIENCEDEFICIENCEDEFICIENCE			TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	age 16	2 900			
2 900	verified R2 should I reposition every two shift should look at times and attend fir been repositioned a R3's admission rec diagnoses included dementia, and a dis vertebra. R3's quarterly MDS had severe cognitiv care, was total dep mobility, transfers, a further indicated R3	and toileting. R3's MDS bakes always incontinent of and toileting. R3's MDS bakes always incontinent of and was at risk for pressure				
	indicated R3 was a	ure ulcers dated 1/5/21, t risk for development of cording the Braden Scale, and cers.				
	at risk for skin brea	ated 9/26/19, indicted R3 was kdown related to impaired ed staff to turn and reposition and as needed.				
	was incontinent of t	eet dated 2/2/21, indicated R3 bowel and bladder, required eting, and repositioning.				
	2/3/21, indicted R3 staff for bed mobilit assist with toileting,	ant Kardex and ng documentation sheet dated required assistance of one ty, repositioning, two staff , and transferred with a Hoyer . R3's toileting/repositioning				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00583	B. WING		C 02/04/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	C	NT AVENUE I, 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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 17	2 900			
		et for the day 2/3/21, indicated d repositioned at 11:20 a.m. until 3:15 p.m.				
	and 2/3/21, indicate needs known, was bladder, and R3 ne by checking and ch as needed. Assess	assessments dated 1/5/21, ed R3 was unable to make incontinent of bowel and eds were anticipated by staff anging every two hours and ment further indicated R3 was ed using a Hoyer lift, and was breakdown.				
	indicated R3 had so	nfection dated 1/26/21, cratches to upper thighs and nt scratching. No other skin				
	observed. R3 was s room facing the wir while, staff was ass 12:26 p.m. staff exc breakfast tray. R3 facing the window, staff entered R3's r NA-A and NA-B we NA-A stated they w R3 was to be turne- every two hours. N last around 11:00 a repositioned at 11:4 unable to use her c	p.m. R3 was continuously sitting in a wheelchair in her adow, back toward the door sisting R3 with breakfast. At cited R3's room with her continued to be positioned with back toward the door. No oom until 3:00 p.m. when re about to enter R3's room. ere going check on R3, and d/repositioned, and toileted A-B stated R3 was toileted .m. and verified R3's was last t0 a.m. NA-A stated R3 was all light, and was dependent and repositioning needs.				
	entered R3's room repositioning and ir brief. NA-B verified	o.m. RN-A, NA-A, and NA-B and assisted with o changing R3's incontinent I R3's brief was incontinent of ated. RN-A assessed R3's				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00583		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/04/2021	
				02/	04/2021	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	С	NT AVENUE H, MN 55734			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ge 18	2 900			
	escorted areas to h	essure related skin erified R3's had self-inflicted ips and buttocks, blanchable and no open areas.				
	toileting and reposit the nurse's desk, in 11:20 a.m. on the d	o.m. RN-A verified R3's tioning documentation sheet a idicated R3 was toileted last at ay shift, and R3 was over the nd repositioning schedule.				
	toileting and reposit on 2/3/21, indicated	a.m. the DON verified R3's tioning documentation sheet I R3 was toileted and I0 a.m. and 3:15 p.m. and not being followed.				
	Management date a will be reviewed and annually and upon a Tissue tolerance ob completed on admi upon significant cha pressure related sk perform routine skin nurses will be notifie	kin Assessment and Wound 7/18, directed Braden Scales d completed quarterly, significant change in condition pservation and evaluation was ssion/re-admission, annually, ange and with development of in impairment. Staff will n inspections with daily cares, ed of skin changes and weekly be competed by licensed staff	/			
	The Director of Nur develop, review, an procedures to ensu pressure ulcer unle and residents who receiving the prope promote healing, pr new pressure ulcer The DON or design	HOD OF CORRECTION: sing (DON) or designee could d/or revise policies and re residents do not develop a ss it is clinically unavoidable, do have pressure ulcers are r care and services needed to revent infection and promote s from developing. the policies and procedures.				

Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00583		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
		B. WING	B. WING		02/04/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	FERVIEW WOODS LL		NT AVENUE H, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From page 19		2 900			
	The DON or designee could develop monitoring systems to ensure ongoing compliance.					
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		9			