Electronically Submitted
April 5, 2021

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

RE: CCN: 245277
Cycle Start Date: March 19, 2021

Dear Administrator:

On March 19, 2021, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On March 19, 2021, the situation of immediate jeopardy to potential health and safety cited at F 600 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 20, 2021.

This Department is also recommending 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 April 20, 2021, (42 CFR 488.417 (b)), They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 20, 2021, (42 CFR 488.417 (b)).

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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Waterview Woods Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 19, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

DEPARTMENT CONTACT

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

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

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, Licensing and Certification Program 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 September 19, 2021 (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 DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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 03/19/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/17/21, through 3/19/21, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. The IJ began on 3/12/21, when a staff forcibly removed R1's clothing during the night, and R1 felt he had been sexually abused. The nurse consultants (NC)-A and NC-B were notified of the IJ on 3/18/21, at 3:52 p.m. The IJ was removed on 3/19/21, at 9:46 a.m. The following complaints were found to be SUBSTANTIATED: H5277054C (MN70916) with a deficiency cited at F600, F609, F610. H5277056C (MN57933) with no deficiencies cited due to actions implemented by the facility prior to survey. H5277057C (MN59822) with no deficiencies cited due to actions implemented by the facility prior to survey. H5277059C (MN60556) with no deficiencies cited due to actions implemented by the facility prior to survey. H5277060C (MN67751) with no deficiencies cited due to actions implemented by the facility prior to survey. H5277061C (MN49088) with no deficiencies cited due to actions implemented by the facility prior to survey.	F 000		

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

Electronically Signed | 04/07/2021

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

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F 000	Continued From page 1 The following complaints were found to be UNSUBSTANTIATED: H5277058C (MN64033) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an 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		

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F 000	Continued From page 3	F 000		

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F 000	Continued From page 4	F 000		
	Use initial recertificaiton or abbreviated comments and then add: The survey resulted in an Immediate Jeopardy (IJ) at (tag number) when ..... add IJ information from the DPS at the tag number. The IJ began on (month, date and year), and the immediacy was removed on (month date and year). The above findings constituted substandard quality of care, and an extended survey was conducted from (month, date year) to (month, date, year). If there was no SQC, tag issued, do not use the above statement.			
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse,	F 600		4/6/21

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F 600	Continued From page 5 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from alleged abuse for 1 of 7 residents (R1) reviewed for abuse. This resulted in an immediate jeopardy (IJ) for R1, who felt he had been sexually abused. The IJ began on 3/12/21, when R1 alleged nursing assistant (NA)-A forcibly removed his clothing during the night, and R1 felt he had been sexually abused. The IJ was identified on 3/18/21, and nurse consultants (NC)-A and NC-B were notified of the IJ at 3:52 p.m. on 3/18/21. The IJ was removed on 3/19/21, at 9:46 a.m., however, noncompliance remained at the lower scope and severity level of D (isolated, with no actual harm with potential for more than minimal harm). Findings include: R1's Transfer/Discharge Report printed 3/22/21, indicated R1's diagnosis included non-displaced fracture of posterior wall of right acetabulum with routine healing (hip fracture), and humerus fracture.	F 600	F 600 Free from Abuse and Neglect Immediate Corrective Action: NA-A no longer works for facility. Corrective Action as it applies to others: The Policy for Abuse Prohibition/Vulnerable Adult Plan was reviewed and remains current. All staff received education regarding Abuse Prevention/Prohibition specific to reporting, listening to resident concerns and refusals of cares. Administrator, Administrator Designee, Director of Nursing, Nurse Manager and Social Worker were educated on the investigative process to include removing any staff member(s) named as an alleged perpetrator from the floor until the investigation is completed and course of action is determined. Date of Compliance: 4/6/21 Recurrence will be prevented by: The Administrator or designee will complete 5 audits on staff knowledge 5 times/week x 2 weeks, weekly x 4 weeks and then monthly x 3 months. Audits will	

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F 600	Continued From page 6 R1's admission Minimum Data Set (MDS) dated 3/8/21, identified R1 was cognitively intact, had clear speech, was able to understand others and be understood. R1's MDS further indicated he required extensive assistance of one with transfers, walking, dressing, toilet use, and personal hygiene. R1's MDS further indicated he was always continent of bladder. R1's care plan initiated on 3/2/21, indicated R1 had a self-care deficit, and would be dressed, groomed, and bathed per his preferences. On 3/17/21, at 1:22 p.m. R1 was interviewed. R1 stated during the night on 3/12/21, he had applied lotion to his legs, then asked staff to help him pull up his pants. R1 stated nursing assistant (NA)-A came in, removed his pants and underwear, and said she was going to change his clothing. R1 stated he told her to stop, but she continued to forcibly take off his clothes, and put other clothes on him. R1 said he was not wet, he never wet his pants, and he did not wear an incontinent brief. R1 said he felt violated, and said he knows how women must feel when they are raped, and someone does not stop when they are told to. R1 stated he reported this incident to many staff. R1's Electronic Medical Record (EMR) progress notes from 3/11/21, through 3/19/21 lacked indication of R1's allegation of abuse. On 3/17/21, at 2:14 p.m. NA-A was interviewed. NA-A stated she did not know resident names, only room numbers. NA-A stated her care guide worksheet did not indicate who was continent or incontinent. NA-A stated when she answered call lights, she checked to see if the residents were wet. NA-A stated that night she was making	F 600	consist of staff knowledge questions regarding abuse prevention and reporting. QAPI Committee will review for ongoing audits. The Social Services Director or Designee will complete 5 audits with 5 residents 5 times/week x 2 weeks, weekly x 4 weeks, and then monthly x 3 months. Audits will consist of questions to the resident regarding specifically if they feel safe in the facility, do they have any concerns that they would like us to know about, do they have any concerns related to their care, do they have any concerns with how employees treat them, and is there anything else they would like to share. QAPI Committee will review for ongoing audits.	

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F 600	Continued From page 7	F 600		

rounds, and R1's light went on. NA-A stated she was having trouble understanding R1, so she checked to see if he was wet, he was not, so she covered him with a blanket and left the room.

-at 2:30 p.m.. NA-B was interviewed. NA-B stated she was familiar with R1, and was aware that he was continent of bladder. NA-B stated R1 did not wear an incontinent brief, and always wore "boxers."

-at 2:38 p.m. NA-C was interviewed. NA-C stated she was familiar with R1. NA-C stated R1 never wore an incontinent brief, he always wore boxers, and was continent of bladder. NA-C stated, "After they have been here awhile, you get to know who is continent all the time."

-at 3:20 p.m. NA-D was interviewed. NA-D stated he usually looked at the care plan on the computer to know how to care for residents. NA-D was familiar with R1, and stated R1 wore underwear.

-at 3:38 p.m. NA-E was interviewed. NA-E stated R1 "always wears underwear."

On 3/18/21, at 9:07 a.m. social worker (SW)-A was interviewed. SW-A stated the director of nursing (DON) came to her on 3/12/21, and told her R1 had some concerns. SW-A stated she spoke to R1, who told her what occurred. SW-A stated R1 told her he knew how a woman must feel when raped by a man when she tells him no. SW-A stated she thought NA-A had been removed from the schedule for the night of 3/12/21, through 3/13/21, pending investigation, but the administrator designee was unable to get in touch with NA-A, and so did not remove her

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F 600	Continued From page 8	F 600		

from the schedule, and let her continue to work.

Individual Employee Time Card provided by the facility, NA-A was not removed from the schedule pending the investigation of the incident, and worked the night of 3/13/21, punching in at 10:37 p.m. and punching out at 6:56 a.m. on 3/14/21.

-at 9:21 a.m. the DON was interviewed. The DON stated the morning of 3/12/21, a staff person reported to her that R1 was upset, and said a night staff person forcibly removed his clothes. The DON said she reported this to the SW and the nurse consultant (NC). The DON said she did not think about removing NA-A from the schedule that day pending investigation, and she was not aware when NA-A worked again. The DON stated she did talk to R1 at a later date, and he told her he knew how a woman must feel when raped by a man when she tells him no.

On 3/19/21, at 10:54 a.m. the DON was interviewed. The DON stated when there was an allegation of abuse, the first step was to ensure the safety of the resident, and if an employee was the alleged perpetrator, they would be removed from the facility pending an investigation. The DON stated the administrator would need to be notified, and the report to the State Agency (SA) would need to be made within two hours.

-11:03 a.m. SW-A was interviewed. SW-A stated staff need to report allegations of abuse immediately, and need to report abuse to the DON and the administrator.

-at 11:25 a.m. the administrator was interviewed. The administrator stated staff need to report allegations of abuse immediately to their

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 03/19/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9 immediate supervisor. The facility policy Abuse Prohibition/Vulnerable Adult Plan dated 7/5/19, directed all staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin. The policy further identified the immediate supervisor will be notified immediately. The policy directs if the abuse is staff to resident alleged or suspected abuse, the staff person will be immediately suspended until the investigation is completed. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The IJ that began on 3/12/21, was removed on 3/19/21, when the facility implemented corrective actions which included the following: The facility interviewed all residents and none had concerns regarding abuse, and all staff were educated on the abuse policy and abuse reporting.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 609		4/6/21

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F 609	Continued From page 10 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately (within two hours) to the administrator and State Agency (SA) for 1 of 7 residents (R1) reviewed for abuse. Findings include: R1's Transfer/Discharge Report printed 3/22/21, indicated R1's diagnosis included non-displaced fracture of posterior wall of right acetabulum with routine healing (hip fracture), and humerus fracture. R1's admission Minimum Data Set (MDS) dated 3/8/21, identified R1 was cognitively intact, had clear speech, was able to understand others and be understood. R1's MDS further indicated he required extensive assistance of one with transfers, walking, dressing, toilet use, and personal hygiene. R1's MDS further indicated he	F 609	F 609 Reporting of Alleged Violations Immediate Corrective Action: NA-A no longer works for facility. Corrective Action as it applies to others: The Policy for Abuse Prohibition/Vulnerable Adult Plan was reviewed and remains current. All staff received education regarding Abuse Prevention/Prohibition specific to reporting, listening to resident concerns and refusals of cares. Administrator, Administrator Designee, Director of Nursing, Nurse Manager and Social Worker were educated on the investigative process to include removing any staff member(s) named as an alleged perpetrator from the floor until the investigation is completed and course of action is determined, need to report suspected abuse to OHFC not later than 2 hours after forming the suspicion of	

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F 609	Continued From page 11 was always continent of bladder. R1's care plan initiated on 3/2/21, indicated R1 had a self-care deficit, and would be dressed, groomed, and bathed per his preferences. On 3/12/21, at 1:43 p.m. a facility incident report submitted to the SA indicated R1 had reported a staff, nursing assistant (NA)-A, answered his call light at approximately 4:00 a.m. R1 wanted help pulling up his underwear and pants after putting lotion on his legs. R1 reported NA-A felt his pants, then went to grab a new pair of pants and a shirt from his closet. R1 told NA-A he did not urinate and was not wet, and he told NA-A to stop. R1 stated she continued to change him. R1 reported that he felt like he was raped, and he now knows how a female feels when she says stop. On 3/18/21, at 9:07 a.m. social worker (SW)-A was interviewed. SW-A stated on 3/12/21, the director of nursing (DON) came to her and told her R1 had some concerns. SW-A spoke to R1, who told her what occurred. SW-A stated R1 told her he knew how a woman must feel when raped by a man when she tells him no. -at 9:21 a.m. the DON was interviewed. The DON stated the morning of 3/12/21, a staff person reported to her that R1 was upset, and said a night staff person forcibly removed his clothes. The DON stated the staff person told her R1 said he knew how a woman must feel when raped by a man when she tells him no. The DON said she reported this to the SW and the nurse consultant (NC). The DON said she did not think about removing NA-A from the schedule that day pending investigation, and she was not aware when NA-A worked again. The DON stated she	F 609	abuse, Date of Compliance: 4/6/21 Recurrence will be prevented by: The Administrator or designee will complete audits on all new OHFC reports weekly x 4 and then monthly x 2 to assure the Abuse Prevention Plan has been followed to include timely reporting. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits.	

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F 609	Continued From page 12	F 609		

did talk to R1 at a later date, and he told her he knew how a woman must feel when raped by a man when she tells him no.

On 3/19/21, at 10:54 a.m. the DON was interviewed. The DON stated when there was an allegation of abuse, the first step was to ensure the safety of the resident, and if an employee was the alleged perpetrator, they would be removed from the facility pending an investigation. The DON stated the administrator would need to be notified, and the report to the State Agency (SA) would need to be made within two hours. No explanation of why the abuse was not reported was provided.

-11:03 a.m. SW-A was interviewed. SW-A stated staff need to report abuse immediately to the DON and the administrator. SW-A did not provide an explanation of why the abuse was not reported within two hours.

-at 11:25 a.m. the administrator was interviewed. The administrator stated staff need to report allegations of abuse immediately to their immediate supervisor.

The facility policy Abuse Prohibition/Vulnerable Adult Plan dated 7/5/19, directed all staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin. The policy further identified the immediate supervisor will be notified immediately. The policy directed if the abuse is staff to resident alleged or suspected abuse, the staff person will be immediately suspended until the investigation is completed. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with

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F 609	Continued From page 13 resulting physical harm, pain or mental anguish. The policy further directed staff to report suspected abuse to the Office of Health Facility Complaints (OHFC) not later than two hours after forming the suspicion of abuse.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate an allegation of abuse, and protect the resident during the investigation, for 1 of 7 residents (R1) reviewed for abuse. Findings include: R1's Transfer/Discharge Report printed 3/22/21,	F 610	F 610 Investigate/Prevent/Correct Alleged Violation Immediate Corrective Action: NA-A no longer works for facility. Corrective Action as it applies to others: The Policy for Abuse Prohibition/Vulnerable Adult Plan was reviewed and remains current. All staff received education regarding Abuse Prevention/Prohibition specific to	4/6/21

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F 610	Continued From page 14 indicated R1's diagnosis included non-displaced fracture of posterior wall of right acetabulum with routine healing (hip fracture), and humerus fracture. R1's admission Minimum Data Set (MDS) dated 3/8/21, identified R1 was cognitively intact, had clear speech, was able to understand others and be understood. R1's MDS further indicated he required extensive assistance of one with transfers, walking, dressing, toilet use, and personal hygiene. R1's MDS further indicated he was always continent of bladder. R1's care plan initiated on 3/2/21, lacked indication of R1's vulnerable adult status. On 3/17/21, at 1:22 p.m. R1 was interviewed. R1 stated during the night on 3/12/21, he had applied lotion to his legs, then asked staff to help him pull up his pants. R1 stated nursing assistant (NA)-A came in, removed his pants and underwear, and said she was going to change his clothing. R1 stated he told her to stop, but she continued to forcibly take off his clothes, and put other clothes on him. R1 said he was not wet, he never wet his pants, and he did not wear an incontinent brief. R1 said he felt violated, and said he knows how women must feel when they are raped, and someone does not stop when they are told to. R1 stated he reported this incident to many staff. Individual Employee Time Card provided by the facility, NA-A was not removed from the schedule pending the investigation of the incident, and worked the night of 3/13/21, punching in at 10:37 p.m. and punching out at 6:56 a.m. on 3/14/21. On 3/17/21, at 2:14 p.m. NA-A was interviewed.	F 610	reporting, listening to resident concerns and refusals of cares. Administrator, Administrator Designee, Director of Nursing, Nurse Manager and Social Worker were educated on the investigative process to include removing any staff member(s) named as an alleged perpetrator from the floor until the investigation is completed and course of action is determined, need to report suspected abuse to OHFC not later than 2 hours after forming the suspicion of abuse, and completing a full investigation and including getting statements from resident(s) affected, other resident(s) at risk, and staff to put in file. Date of Compliance: 4/6/21 Recurrence will be prevented by: The Administrator or designee will complete audits on all new OHFC reports weekly x 4 and then monthly x 2 to assure the Abuse Prevention Plan has been followed to include a full investigation process and the removal of alleged perpetrator(s) from the floor until the investigation is completed and course of action is determined. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits.	

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F 610	Continued From page 15	F 610		

NA-A stated she did not know resident names, only room numbers. NA-A stated her care guide worksheet did not indicate who was continent or incontinent. NA-A stated when she answered call lights, she checked to see if the residents were wet. NA-A stated that night she was making rounds, and R1's light went on. NA-A stated she was having trouble understanding R1, so she checked to see if he was wet, he wasn't, so she covered him with a blanket and left the room.

The facility investigation dated 3/12/21, indicated eight residents were interviewed. The form indicated the residents were asked, "Do you feel safe in the facility?" and "Does staff treat you with respect?" All residents interviewed indicated "Yes" to both questions. An email dated 3/15/21, written by the administrator designee indicated she was unable to reach NA-A over the weekend. The administrator designee spoke with NA-A on 3/15/21, at 12:13 p.m. NA-A stated she did not know the resident by name, but she knew the resident by room number. The email indicated NA-A changed the resident's wet bedding and wet clothing, and applied barrier cream to his bottom. On 3/26/21, staff was provided education: "When providing cares to resident, please allow resident to guide pace of cares to avoid miscommunication." The investigation lacked indication of interview of R1, and if any other residents felt they had been abused.

The facility policy Abuse Prohibition/Vulnerable Adult Plan dated 7/5/19, directed investigations of alleged abuse may include interviewing staff, residents, or other witnesses to the incident. Corrective action based on the investigation will be completed (e.g., change of procedure, training, discipline or discharge of staff, etc.). The

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F 610	Continued From page 16 social worker or other staff as appropriate will provide ongoing support and counseling to the resident and family as needed.	F 610		

Electronically delivered
April 5, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: PNRP11

Dear Administrator:

The above facility was surveyed on March 17, 2021 through March 19, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00583	A. BUILDING: _____ B. WING _____	C 03/19/2021

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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 3/17/21, through 3/19/21, a standard abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be OUT of compliance with the MN State Licensure. The following complaints were found to be	2 000	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	

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2 000	Continued From page 1 SUBSTANTIATED: H5277054C (MN70916) with a licensing order issued at MN Rule 1980. H5277056C (MN57933) with no licensing orders issued. H5277057C (MN59822) with no licensing orders issued. H5277059C (MN60556) with no licensing orders issued. H5277060C (MN67751) with no licensing orders issued. H5277061C (MN49088) with no licensing orders issued. The following complaints were found to be UNSUBSTANTIATED: H5277058C (MN64033) 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	Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a	21980		4/6/21

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21980	Continued From page 2	21980		

vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or

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	00583	A. BUILDING: _____ B. WING _____	C 03/19/2021

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

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21980	Continued From page 3 directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately (within two hours) to the administrator and State Agency (SA) for 1 of 7 residents (R1) reviewed for abuse. Findings include: R1's Transfer/Discharge Report printed 3/22/21, indicated R1's diagnosis included non-displaced fracture of posterior wall of right acetabulum with routine healing (hip fracture), and humerus fracture. R1's admission Minimum Data Set (MDS) dated 3/8/21, identified R1 was cognitively intact, had clear speech, was able to understand others and be understood. R1's MDS further indicated he required extensive assistance of one with transfers, walking, dressing, toilet use, and personal hygiene. R1's MDS further indicated he was always continent of bladder. R1's care plan initiated on 3/2/21, indicated R1 had a self-care deficit, and would be dressed, groomed, and bathed per his preferences. On 3/12/21, at 1:43 p.m. a facility incident report submitted to the SA indicated R1 had reported a staff, nursing assistant (NA)-A, answered his call	21980	F 600 Free from Abuse and Neglect Immediate Corrective Action: NA-A no longer works for facility. Corrective Action as it applies to others: The Policy for Abuse Prohibition/Vulnerable Adult Plan was reviewed and remains current. All staff received education regarding Abuse Prevention/Prohibition specific to reporting, listening to resident concerns and refusals of cares. Administrator, Administrator Designee, Director of Nursing, Nurse Manager and Social Worker were educated on the investigative process to include removing any staff member(s) named as an alleged perpetrator from the floor until the investigation is completed and course of action is determined. Date of Compliance: 4/6/21 Recurrence will be prevented by: The Administrator or designee will complete 5 audits on staff knowledge 5 times/week x 2 weeks, weekly x 4 weeks and then monthly x 3 months. Audits will consist of staff knowledge questions regarding abuse prevention and reporting. QAPI Committee will review for ongoing audits. The Social Services Director or Designee	

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21980	Continued From page 4 light at approximately 4:00 a.m. R1 wanted help pulling up his underwear and pants after putting lotion on his legs. R1 reported NA-A felt his pants, then went to grab a new pair of pants and a shirt from his closet. R1 told NA-A he did not urinate and was not wet, and he told NA-A to stop. R1 stated she continued to change him. R1 reported that he felt like he was raped, and he now knows how a female feels when she says stop. On 3/18/21, at 9:07 a.m. social worker (SW)-A was interviewed. SW-A stated on 3/12/21, the director of nursing (DON) came to her and told her R1 had some concerns. SW-A spoke to R1, who told her what occurred. SW-A stated R1 told her he knew how a woman must feel when raped by a man when she tells him no. -at 9:21 a.m. the DON was interviewed. The DON stated the morning of 3/12/21, a staff person reported to her that R1 was upset, and said a night staff person forcibly removed his clothes. The DON stated the staff person told her R1 said he knew how a woman must feel when raped by a man when she tells him no. The DON said she reported this to the SW and the nurse consultant (NC). The DON said she did not think about removing NA-A from the schedule that day pending investigation, and she was not aware when NA-A worked again. The DON stated she did talk to R1 at a later date, and he told her he knew how a woman must feel when raped by a man when she tells him no. On 3/19/21, at 10:54 a.m. the DON was interviewed. The DON stated when there was an allegation of abuse, the first step was to ensure the safety of the resident, and if an employee was the alleged perpetrator, they would be removed from the facility pending an investigation. The	21980	will complete 5 audits with 5 residents 5 times/week x 2 weeks, weekly x 4 weeks, and then monthly x 3 months. Audits will consist of questions to the resident regarding specifically if they feel safe in the facility, do they have any concerns that they would like us to know about, do they have any concerns related to their care, do they have any concerns with how employees treat them, and is there anything else they would like to share. QAPI Committee will review for ongoing audits.	

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21980	Continued From page 5 DON stated the administrator would need to be notified, and the report to the State Agency (SA) would need to be made within two hours. No explanation of why the abuse was not reported was provided. -11:03 a.m. SW-A was interviewed. SW-A stated staff need to report abuse immediately to the DON and the administrator. SW-A did not provide an explanation of why the abuse was not reported within two hours. -at 11:25 a.m. the administrator was interviewed. The administrator stated staff need to report allegations of abuse immediately to their immediate supervisor. The facility policy Abuse Prohibition/Vulnerable Adult Plan dated 7/5/19, directed all staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin. The policy further identified the immediate supervisor will be notified immediately. The policy directed if the abuse is staff to resident alleged or suspected abuse, the staff person will be immediately suspended until the investigation is completed. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The policy further directed staff to report suspected abuse to the Office of Health Facility Complaints (OHFC) not later than two hours after forming the suspicion of abuse. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility	21980		

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21980	Continued From page 6 should re-educate staff identified in the citation to policies and procedures, and audit all complaints of alleged abuse or neglect for a set determined time. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		