Electronically delivered
May 11, 2021

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

RE: CCN: 245277
Cycle Start Date: April 27, 2021

Dear Administrator:

On April 27, 2021, a survey was completed at your facility by the Minnesota Departments 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 27, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 27, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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 04/27/2021

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 4/26/21, through 4/27/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5277064C (MN68902), with deficiencies cited at F686 and F690. H5277065C (MN70018), with deficiencies cited at F686 and F690. H5277067C (MN72026), with deficiencies cited at F686 and F690. The following complaints were found to be SUBSTANTIATED with no deficiencies cited due to actions implemented by the facility prior to survey: H5277063C (MN64834) H5277066C (MN72148) H5277068C (MN72127) H5277069C (MN72224) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		5/18/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/18/2021

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 686 SS=D	Continued From page 1 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning to promote healing and prevent development of new pressure ulcers for 1 of 3 (R1) residents reviewed repositioning. Findings include: Pressure ulcer/injury stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 2 Pressure Injury: 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. Stage 4 Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable	F 686	Immediate corrective action: Resident #1 was toileted/repositioned as soon as issue was identified. Skin check was completed with no new concerns noted. NARs assigned to these residents were re-educated on the need to provide these services timely. Corrective action as it applies to others: The ADL Assist per Care Plan Policy was reviewed and remains current. All nurses, TMAs, and NARs were re-educated on the ADL Assist Care Plan Policy specifically providing assistance with toileting/repositioning per resident individualized care pan. All residents needing assistance with toileting/repositioning will be provided this	

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F 686	Continued From page 2 fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. R1's Admission Record printed 4/27/21, indicated R1's diagnoses included multiple sclerosis (disabling disease of the brain and spinal cord), urinary tract infection, and Stage 4 pressure ulcer of left buttock. R1's annual Minimum Data Set (MDS) dated 3/5/21, indicated R1 indicated R1's cognition was severely impaired, she had no rejection of cares, she required extensive assistance of two staff for bed mobility and repositioning, and required the use of mechanical lift (Hoyer lift) for all transfers. R1's MDS further indicated R1 was always incontinent of bladder and bladder, had existing Stage 2 and Stage 4 pressure ulcers, and was at risk for developing newly acquired pressure ulcers. R1's Care Area Assessment (CAA) f or pressure ulcers dated 3/4/21, indicated R1 was at risk for pressure developing ulcers according to the Braden Scale (a tool used to assist the risk of pressure ulcer development), had had existing unhealed Stage 2 and Stage 4 pressure ulcers, and was at risk for developing newly acquired pressure ulcers. R1's care plan initiated 1/11/21, identified R1 having a pressure ulcer to left buttock related to immobility, with a goal to be showing signs of healing wound and remain free from infection. R1's care plan interventions directed staff to provide repositioning every two hours, turning	F 686	assistance per care plan/care sheet details. Date of Compliance: 5/18/21 Recurrence will be prevented by: Audits of 5 random residents will be completed weekly x 4 then monthly x 2 months to assure timely assistance is provided for toileting and repositioning. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	

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F 686	Continued From page 3	F 686		

from side to side with pillows between knees, and directed staff to follow facility protocol's for the prevention and treatment of skin breakdown.

R1's nursing assistant care guide sheet dated 4/27/21, indicated R1 was incontinent, required assistance with toileting, and directed staff to reposition and toilet R1 every two hours.

On 4/7/21, R1's progress notes indicated R1 had been sent to hospital and was admitted for treatment for osteomyelitis (infection spread to the bone).

On 4/12/21, R1's progress notes indicated R1 had been discharged from the hospital and readmitted to the facility after being diagnosed with osteomyelitis. R1's Braden Scale Assessment completed at the time of readmission was a 12, whcih indicated R1 was at high risk for skin issues/concerns. R1 was readmitted to the facility for hospice care with comfort-focused treatment.

On 4/27/21, at 7:22 a.m. R1 was continously observed sitting in wheelchair (W/C/) in her room in front of the television. At 7:50 a.m. an unidentified female staff was observed entering R1's room and proceeded to transport R1 via her W/C to the dining room for breakfast meal service. At 9:02 a.m. nursing assistant (NA)-A was observed transporting R1 via W/C from the dining room to R1's room. NA-A positioned R1's W/C in front of the TV and exited R1's room. NA-A did not reposition R1. At 9:51 a.m. R1 was interviewed and stated she had been in her W/C since her morning cares were provided, and staff frequently left her in her W/C for long periods of time. R1 further stated leaving her in her W/C

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F 686	Continued From page 4	F 686		

caused pain to her buttock region. At 10:04 a.m. NA-A was interviewed and stated R1 should be repositioned every two hours. NA-A stated R1 had not been repositioned since morning cares were completed. NA-A stated she was aware that R1 required repositioning to be provided every two hours, but had not provided the cares per R1's care guide. NA-A stated repositioning was important to prevent skin breakdown.

On 4/27/21, at 10:16 a.m. (2 hours and 54 minutes since continuous observations started) registered nurse (RN)-A entered R1's room. RN-A stated staff were to be repositioning residients per the resident's individual care plan to prevent new or worsening skin breakdown. RN-A verified R1 currently had a left buttock pressure ulcer. RN-A completed a skin assessment on R1. R1 was noted to have blanchable redness to both left and right buttocks which was noted to dissipate (dissolve) with repositioning and light massage to the area. RN-A removed R1's old dressing, and stated R1's left buttock pressure ulcer appeared to be doing good. RN-A stated R1's left buttock pressure ulcer was measured at 7.2 cm (centimeters) in length by 3.1 cm in width, with the deepest measurement 3.0 cm. R1's left pressure ulcer was noted to be beefy red in color with no odor noted. RN-A completed the clean dressing change.

On 4/27/21, at 2:28 p.m. the director of nursing (DON) was interviewed and stated her expectation was for residents to be repositioned and toileted timely, and for staff to get help if they were unable to complete it timely. The DON verified R1 had a pressure ulcer on her coccyx and stated it was very important that repositioning and incontinence care was being provided for R1

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F 686	Continued From page 5 timely to prevent worsening or additional skin breakdown from developing. The facility policy titled Repositioning revised date 5/13, directed staff to provide repositioning per resident's individual care plan to promote comfort, and to prevent skin breakdown. The policies general guidelines included repositioning is critical for a resident who is immobile or dependent upon staff for repositioning.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 690		5/18/21

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F 690	Continued From page 6 continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure incontinence cares were provided per care plan for 1 of 3 residents (R1) reviewed for incontinence cares. . Findings include: R1's Admission Record printed 4/27/21, indicated R1's diagnoses included multiple sclerosis (disabling disease of the brain and spinal cord), urinary tract infection, and Stage 4 pressure ulcer of left buttock (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer). R1's re-admission Minimum Data Set (MDS) dated 3/9/21, indicated R1's cognition was severely impaired, she required extensive assistance of two staff for bed mobility, and required the use of mechanical lift (Hoyer lift) for all transfers. R1's MDS further indicated R1 was always incontinent of bladder and bowel, and was totally dependent on staff for toileting. R1's Care Area Assessment (CAA) for urinary incontinence dated 3/5/21, indicated R1 received total assistance with toileting and was always incontinent. R1's CAA indicated R1 was alert staff	F 690	Immediate Corrective Action: Resident #1 was toileted/repositioned as soon as issue was identified. Skin check was completed with no new concerns noted. NARs assigned to these residents were re-educated on the need to provide these services timely. Corrective Action as it applies to others: The ADL Assist per Care Plan Policy was reviewed and remains current. All nurses, TMAs, and NARs were re-educated on the ADL Assist per Care Plan Policy specifically providing assistance with toileting/repositioning per resident individualized care pan. All residents needing assistance with toileting/repositioning will be provided this assistance per care plan/care sheet details. Date of Compliance: 5/18/21 Recurrence will be prevented by: Audits of 5 random residents will be completed weekly x 4 then monthly x 2 months to assure timely assistance is provided for toileting and repositioning.	

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F 690	Continued From page 7 with cognitive impairment. Staff were to toilet/change per plan of care. The CAA further indicated R1 required incontinent pads to aid in keeping skin clean and dry. Goals included for R1 to remain dry, clean, and free from breakdown. R1's care plan initiated 3/10/20, indicated R1 was incontinent of bladder and bowel, with a goal to be free from signs/symptoms of urinary tract infection. R1's care plan directed staff to provide assistance of one to two staff for toileting cares, and to provide assistance with peri-cares and incontinent product and to change R1 as needed. R1's nursing assistant care guide sheet dated 4/27/21, indicated R1 was incontinent, required assistance with toileting, and directed staff to reposition and toilet her every two hours. R1's Bladder Evaluation dated 3/4/21, indicated R1 risk factors included needing Hoyer assistance with all transfers, quadriplegia, retention of urine, urge incontinence, overactive bladder, and mild cognitive impairment. Current interventions included staff assistance with toileting needs, helping with peri cares and providing and assist with changing incontinence product. R1 was to be on a check and change toileting program every 2-3 hours and as needed. On 4/27/21, at 7:22 a.m. R1 was continuously observed. R1 was seated in her wheelchair (W/C/) in her room in front of the television. At 7:50 a.m. an unidentified female staff was observed entering R1's room and proceeded to transport R1 via her W/C to the dining room for breakfast meal service. At 9:02 a.m. nursing assistant (NA)-A was observed transporting R1 via W/C from the dining room to her room. NA-A	F 690	The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	

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F 690	Continued From page 8	F 690		

positioned R1's W/C in front of the TV and exited R1's room. NA-A did not check R1 to see if she was incontinent. At 9:51 a.m. R1 was interviewed and stated she had been in her W/C since her morning cares were provided, and staff frequently left her in her W/C for long periods of time. R1 further stated leaving her in her W/C caused pain to her buttock region. At 10:04 a.m. NA-A was interviewed and stated R1 should be toileted and repositioned every two hours. NA-A stated R1 had not been repositioned or provided incontinence care since morning cares were completed. NA-A stated she was aware that R1 required repositioning and incontinence cares to be provided every two hours but had not provided the cares per R1's care guide. NA-A stated repositioning and incontinence care was important to prevent skin breakdown.

On 4/27/21, at 10:16 a.m. (2 hours and 54 minutes since continuous observations started) registered nurse (RN)-A entered R1's room. RN-A verified R1's incontinent brief was wet with urine, but that R1 had not had a bowel movement. RN-A stated staff were to be repositioning, toileting, and providing peri care per resident's individual care plan to prevent new or worsening skin breakdown.

On 4/27/21, at 2:28 p.m. the director of nursing (DON) was interviewed and stated her expectation was for residents to be repositioned and toileted timely, and for staff to get help if they were unable to complete it timely. The DON verified R1 had a pressure ulcer on her coccyx and stated it was very important that repositioning and incontinence care was being provided for R1 timely to prevent worsening or additional skin breakdown from developing.

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F 690	Continued From page 9 The facility policy Monarch HealthCare ADL Assistance Per Care Plan revised date 5/18, directed incontinent residents will be checked and toileting according to care plan. The facility policy Monarch Toileting Assistance policy revised date 11/19, directed staff to provide clients a safe, hygienic, and thorough toileting assistance.	F 690		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 11, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: Y86G11

Dear Administrator:

The above facility was surveyed on April 26, 2021 through April 27, 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 04/27/2021

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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 4/26/21, through 4/27/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5277064C (MN68902) with a licensing order issued at MN Rule 4658.0525 Subp. 6 B and MN Rule 4658.0525 Subp. 5 A B H5277065C (MN70018) with a licensing order issued at MN Rule 4658.0525 Subp. 6 B and MN Rule 4658.0525 Subp. 5 A B H5277067C (MN72026) with a licensing order issued at MN Rule 4658.0525 Subp. 6 B and MN Rule 4658.0525 Subp. 5 A B The following complaints were found to be SUBSTANTIATED with no deficiencies cited due to actions implemented by the facility prior to survey: H5277063C (MN64834) H5277066C (MN72148) H5277068C (MN72127) H5277069C (MN72224) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health	2 000		

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2 000	Continued From page 2 Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores	2 900		5/17/21

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2 900	Continued From page 3 receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning to promote healing and prevent development of new pressure ulcers for 1 of 3 (R1) residents reviewed repositioning. Findings include: Pressure ulcer/injury stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 2 Pressure Injury: 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. Stage 4 Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. R1's Admission Record printed 4/27/21, indicated R1's diagnoses included multiple sclerosis (disabling disease of the brain and spinal cord), urinary tract infection, and Stage 4 pressure ulcer of left buttock.	2 900	Date of correction: 5/17/2021	

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2 900	Continued From page 4 R1's annual Minimum Data Set (MDS) dated 3/5/21, indicated R1 indicated R1's cognition was severely impaired, she had no rejection of cares, she required extensive assistance of two staff for bed mobility and repositioning, and required the use of mechanical lift (Hoyer lift) for all transfers. R1's MDS further indicated R1 was always incontinent of bladder and bladder, had existing Stage 2 and Stage 4 pressure ulcers, and was at risk for developing newly acquired pressure ulcers. R1's Care Area Assessment (CAA) f or pressure ulcers dated 3/4/21, indicated R1 was at risk for pressure developing ulcers according to the Braden Scale (a tool used to assist the risk of pressure ulcer development), had had existing unhealed Stage 2 and Stage 4 pressure ulcers, and was at risk for developing newly acquired pressure ulcers. R1's care plan initiated 1/11/21, identified R1 having a pressure ulcer to left buttock related to immobility, with a goal to be showing signs of healing wound and remain free from infection. R1's care plan interventions directed staff to provide repositioning every two hours, turning from side to side with pillows between knees, and directed staff to follow facility protocol's for the prevention and treatment of skin breakdown. R1's nursing assistant care guide sheet dated 4/27/21, indicated R1 was incontinent, required assistance with toileting, and directed staff to reposition and toilet R1 every two hours. On 4/7/21, R1's progress notes indicated R1 had been sent to hospital and was admitted for treatment for osteomyelitis (infection spread to the bone).	2 900		

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2 900	Continued From page 5 On 4/12/21, R1's progress notes indicated R1 had been discharged from the hospital and readmitted to the facility after being diagnosed with osteomyelitis. R1's Braden Scale Assessment completed at the time of readmission was a 12, whcih indicated R1 was at high risk for skin issues/concerns. R1 was readmitted to the facility for hospice care with comfort-focused treatment. On 4/27/21, at 7:22 a.m. R1 was continously observed sitting in wheelchair (W/C/) in her room in front of the television. At 7:50 a.m. an unidentified female staff was observed entering R1's room and proceeded to transport R1 via her W/C to the dining room for breakfast meal service. At 9:02 a.m. nursing assistant (NA)-A was observed transporting R1 via W/C from the dining room to R1's room. NA-A positioned R1's W/C in front of the TV and exited R1's room. NA-A did not reposition R1. At 9:51 a.m. R1 was interviewed and stated she had been in her W/C since her morning cares were provided, and staff frequently left her in her W/C for long periods of time. R1 further stated leaving her in her W/C caused pain to her buttock region. At 10:04 a.m. NA-A was interviewed and stated R1 should be repositioned every two hours. NA-A stated R1 had not been repositioned since morning cares were completed. NA-A stated she was aware that R1 required repositioning to be provided every two hours, but had not provided the cares per R1's care guide. NA-A stated repositioning was important to prevent skin breakdown. On 4/27/21, at 10:16 a.m. (2 hours and 54 minutes since continuous observations started) registered nurse (RN)-A entered R1's room. RN-A stated staff were to be repositioning residients per	2 900		

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2 900	Continued From page 6	2 900		

the resident's individual care plan to prevent new or worsening skin breakdown. RN-A verified R1 currently had a left buttock pressure ulcer. RN-A completed a skin assessment on R1. R1 was noted to have blanchable redness to both left and right buttocks which was noted to dissipate (dissolve) with repositioning and light massage to the area. RN-A removed R1's old dressing, and stated R1's left buttock pressure ulcer appeared to be doing good. RN-A stated R1's left buttock pressure ulcer was measured at 7.2 cm (centimeters) in length by 3.1 cm in width, with the deepest measurement 3.0 cm. R1's left pressure ulcer was noted to be beefy red in color with no odor noted. RN-A completed the clean dressing change.

On 4/27/21, at 2:28 p.m. the director of nursing (DON) was interviewed and stated her expectation was for residents to be repositioned and toileted timely, and for staff to get help if they were unable to complete it timely. The DON verified R1 had a pressure ulcer on her coccyx and stated it was very important that repositioning and incontinence care was being provided for R1 timely to prevent worsening or additional skin breakdown from developing.

The facility policy titled Repositioning revised date 5/13, directed staff to provide repositioning per resident's individual care plan to promote comfort, and to prevent skin breakdown. The policies general guidelines included repositioning is critical for a resident who is immobile or dependent upon staff for repositioning.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents do not develop a

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2 900	Continued From page 7 pressure ulcer unless it is clinically unavoidable, and residents who do have pressure ulcers are receiving the proper care and services needed to promote healing, prevent infection and promote new pressure ulcers from developing. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure incontinence cares were provided per care plan for 1 of 3	2 910	Date of Correction: 05/18/2021	5/18/21

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2 910	Continued From page 8 residents (R1) reviewed for incontinence cares. . Findings include: R1's Admission Record printed 4/27/21, indicated R1's diagnoses included multiple sclerosis (disabling disease of the brain and spinal cord), urinary tract infection, and Stage 4 pressure ulcer of left buttock (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer). R1's re-admission Minimum Data Set (MDS) dated 3/9/21, indicated R1's cognition was severely impaired, she required extensive assistance of two staff for bed mobility, and required the use of mechanical lift (Hoyer lift) for all transfers. R1's MDS further indicated R1 was always incontinent of bladder and bowel, and was totally dependent on staff for toileting. R1's Care Area Assessment (CAA) for urinary incontinence dated 3/5/21, indicated R1 received total assistance with toileting and was always incontinent. R1's CAA indicated R1 was alert staff with cognitive impairment. Staff were to toilet/change per plan of care. The CAA further indicated R1 required incontinent pads to aid in keeping skin clean and dry. Goals included for R1 to remain dry, clean, and free from breakdown. R1's care plan initiated 3/10/20, indicated R1 was incontinent of bladder and bowel, with a goal to be free from signs/symptoms of urinary tract infection. R1's care plan directed staff to provide assistance of one to two staff for toileting cares, and to provide assistance with peri-cares and incontinent product and to change R1 as needed. R1's nursing assistant care guide sheet dated	2 910		

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2 910	Continued From page 9 4/27/21, indicated R1 was incontinent, required assistance with toileting, and directed staff to reposition and toilet her every two hours. R1's Bladder Evaluation dated 3/4/21, indicated R1 risk factors included needing Hoyer assistance with all transfers, quadriplegia, retention of urine, urge incontinence, overactive bladder, and mild cognitive impairment. Current interventions included staff assistance with toileting needs, helping with peri cares and providing and assist with changing incontinence product. R1 was to be on a check and change toileting program every 2-3 hours and as needed. On 4/27/21, at 7:22 a.m. R1 was continuously observed. R1 was seated in her wheelchair (W/C/) in her room in front of the television. At 7:50 a.m. an unidentified female staff was observed entering R1's room and proceeded to transport R1 via her W/C to the dining room for breakfast meal service. At 9:02 a.m. nursing assistant (NA)-A was observed transporting R1 via W/C from the dining room to her room. NA-A positioned R1's W/C in front of the TV and exited R1's room. NA-A did not check R1 to see if she was incontinent. At 9:51 a.m. R1 was interviewed and stated she had been in her W/C since her morning cares were provided, and staff frequently left her in her W/C for long periods of time. R1 further stated leaving her in her W/C caused pain to her buttock region. At 10:04 a.m. NA-A was interviewed and stated R1 should be toileted and repositioned every two hours. NA-A stated R1 had not been repositioned or provided incontinence care since morning cares were completed. NA-A stated she was aware that R1 required repositioning and incontinence cares to be provided every two hours but had not provided the cares per R1's care guide. NA-A stated	2 910		

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2 910	Continued From page 10	2 910		

repositioning and incontinence care was important to prevent skin breakdown.

On 4/27/21, at 10:16 a.m. (2 hours and 54 minutes since continuous observations started) registered nurse (RN)-A entered R1's room. RN-A verified R1's incontinent brief was wet with urine, but that R1 had not had a bowel movement. RN-A stated staff were to be repositioning, toileting, and providing peri care per resident's individual care plan to prevent new or worsening skin breakdown.

On 4/27/21, at 2:28 p.m. the director of nursing (DON) was interviewed and stated her expectation was for residents to be repositioned and toileted timely, and for staff to get help if they were unable to complete it timely. The DON verified R1 had a pressure ulcer on her coccyx and stated it was very important that repositioning and incontinence care was being provided for R1 timely to prevent worsening or additional skin breakdown from developing.

The facility policy Monarch HealthCare ADL Assistance Per Care Plan revised date 5/18, directed incontinent residents will be checked and toileting according to care plan.

The facility policy Monarch Toileting Assistance policy revised date 11/19, directed staff to provide clients a safe, hygienic, and thorough toileting assistance.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents receive incontinence cares to prevent skin breakdown and infections and maintain dignity.

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	00583	A. BUILDING: _____ B. WING _____	C 04/27/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 11 The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		