

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: 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.

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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

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

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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.

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Feel free to contact me if you have questions.

Sincerely,

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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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	MB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY IPLETED
		245277	B. WING				C 27/2021
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F 000	INITIAL COMMENT	ſS	F 0(00			
	abbreviated survey Your facility was fou with the requirement Requirements for L The following comp SUBSTANTIATED:	th 4/27/21, a standard was conducted at your facility. and to be NOT in compliance hts of 42 CFR 483, Subpart B, ong Term Care Facilities. Plaints were found to be 1902), with deficiencies cited at					
	H5277065C (MN70 F686 and F690.	018), with deficiencies cited at 026), with deficiencies cited at					
	SUBSTANTIATED	148) 127)					
	as your allegation of Departments accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
	onsite revisit of you validate that substa regulations has bee						
F 686	reatment/Svcs to	Prevent/Heal Pressure Ulcer	F 68	86			5/18/21
	DIRECTOR'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE 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.

PRINTED: 05/24/2021

	-	AND HUMAN SERVICES				FORM	05/24/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		E CONSTRUCTION	(X3) DATE	E SURVEY
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		245277	B. WING_				27/2021
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F 686	Continued From pa	ae 1	F 6	86			
SS=D		-	1.0	00			
	.,						
	§483.25(b) Skin Inte §483.25(b)(1) Press						
	Based on the comp	rehensive assessment of a					
	resident, the facility	must ensure that- es care, consistent with					
	()	ards of practice, to prevent					
		d does not develop pressure					
		dividual's clinical condition hey were unavoidable; and					
		pressure ulcers receives					
		nt and services, consistent					
		andards of practice, to event infection and prevent					
	new ulcers from de	veloping.					
	This REQUIREMEN	NT is not met as evidenced					
		tion, interview, and document			Immediate corrective action:		
		ailed to provide timely					
		mote healing and prevent v pressure ulcers for 1 of 3			Resident #1 was toileted/reposition soon as issue was identified. Skin o		
	(R1) residents revie				was completed with no new concer	ns	
	Eindings include:				noted. NARs assigned to these residuent were re-educated on the need to pr		
	Findings include:				these services timely.	ovide	
		y stages defined by the			-		
	National Pressure l	JIcer Advisory Panel (NPUAP):			Corrective action as it applies to oth	ners:	
	Stage 2 Pressure Ir	njury: Partial-thickness loss of			The ADL Assist per Care Plan Polic	y was	
	skin with exposed of	lermis. The wound bed is			reviewed and remains current.		
		moist, and may also present ured serum-filled blister.			All nurses, TMAs, and NARs were		
	Adipose (fat) is not	visible and deeper tissues are			re-educated on the ADL Assist Care		
		tion tissue, slough and eschar			Policy specifically providing assistant		
	are not present.				with toileting/repositioning per resid individualized care pan.	ent	
		njury: Full-thickness skin and			All residents needing assistance wi		
	tissue loss with exp	osed or directly palpable			toileting/repositioning will be provide	ed this	

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		AND HUMAN SERVICES				FORM	05/24/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
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F 686	Continued From pa	ge 2	F6	686			
	fascia, muscle, tend bone in the ulcer. S visible. Epibole (roll and/or tunneling off anatomical location R1's Admission Ree R1's diagnoses incl (disabling disease of urinary tract infection of left buttock. R1's annual Minimu 3/5/21, indicated R severely impaired, s she required extense bed mobility and re- use of mechanical I R1's MDS further in incontinent of black Stage 2 and Stage risk for developing ulcers. R1's Care Area Ass ulcers dated 3/4/21 pressure developing Braden Scale (a too pressure ulcer developing Braden Scale (a too pressure ulcers. R1's care plan initia having a pressure u immobility, with a g healing wound and R1's care plan initia	don, ligament, cartilage or lough and/or eschar may be ed edges), undermining en occur. Depth varies by			assistance per care plan/care shee 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 months to assure timely assistance provided for toileting and reposition The results of these audits will be s with the facility QAPI committee for on the need to increase, decrease discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	e x 2 is ing. hared input	

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		U PLE CONSTRUCTION	1	E SURVEY
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		c.		(601 GRANT AVENUE		
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					_		
F 686	Continued From pa	ge 3	F 6	686	3		
		th pillows between knees, and					
		ow facility protocol's for the					
		tment of skin breakdown.					
		ant care guide sheet dated					
		R1 was incontinent, required					
		eting, and directed staff to t R1 every two hours.					
	On 4/7/21, R1's pro	gress notes indicated R1 had					
		al and was admitted for					
		myelitis (infection spread to					
	the bone).						
	On 1/12/21 P1's pr	ogress notes indicated R1					
		ed from the hospital and					
		cility after being diagnosed					
	with osteomyelitis.						
	Assessment comple						
		12, whcih indicated R1 was at					
		sues/concerns. R1 was					
	comfort-focused tre	cility for hospice care with					
	connon-locused the	alment.					
	On 4/27/21. at 7:22	a.m. R1 was continously					
		wheelchair (W/C/) in her room					
	in front of the televis	sion. At 7:50 a.m. an					
		staff was observed entering					
		ceeded to transport R1 via her					
		oom for breakfast meal					
		n. nursing assistant (NA)-A sporting R1 via W/C from the					
		room. NA-A positioned R1's					
		TV and exited R1's room.					
		tion R1. At 9:51 a.m. R1 was					
	interviewed and sta	ted she had been in her W/C					
		cares were provided, and staff					
		her W/C for long periods of					
1	ume. K1 further sta	ted leaving her in her W/C					

Facility ID: 00583

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/24/2021 APPROVED
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o N mh w F tr F ir O n m stt o o o n ri ((tt strp((tt p v d O)) e a w v a	IA-A was interview epositioned every t ad not been reposi- vere completed. N/ A1 required repositi- wo hours, but had n A1's care guide. N/ mportant to preven On 4/27/21, at 10:10 ninutes since conti- egistered nurse (R tated staff were to ne resident's individ- r worsening skin b- urrently had a left I ompleted a skin as loted to have blance ght buttocks which dissolve) with repo- ne area. RN-A rem tated R1's left butto b be doing good. R wressure ulcer was centimeters) in leng- ne deepest measur- ressure ulcer was vith no odor noted. Iressing change. On 4/27/21, at 2:28 DON) was interview expectation was for ind toileted timely, vere unable to com erified R1 had a pr ind stated it was ver-	buttock region. At 10:04 a.m. ed and stated R1 should be wo hours. NA-A stated R1 itioned since morning cares A-A stated she was aware that ioning to be provided every not provided the cares per A-A stated repositioning was	F	\$86			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	Сом	E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WAT	ERVIEW WOODS LL	С		601 GRANT AVENUE EVELETH, MN 55734		
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F 686	timely to prevent we breakdown from de The facility policy tit 5/13, directed staff	orsening or additional skin veloping. led Repositioning revised date to provide repositioning per	F 68	36		
	and to prevent skin general guidelines i critical for a residen dependent upon sta	ntinence, Catheter, UTI	F 69	90		5/18/21
	resident who is con admission receives maintain continence	facility must ensure that tinent of bladder and bowel on services and assistance to e unless his or her clinical mes such that continence is				
	incontinence, based comprehensive ass ensure that- (i) A resident who e indwelling catheter resident's clinical co catheterization was (ii) A resident who e indwelling catheter is assessed for rem as possible unless demonstrates that o and (iii) A resident who i receives appropriat	essment, the facility must nters the facility without an is not catheterized unless the ondition demonstrates that				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	05/24/2021 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	TIPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245277	B. WING _			C 27/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		6		601 GRANT AVENUE		
				EVELETH, MN 55734		
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F 690	continence to the ex §483.25(e)(3) For a	tent possible. resident with fecal	F 69	90		
	incontinence, based comprehensive ass ensure that a reside receives appropriate restore as much no possible. This REQUIREMEN by: Based on observat review, the facility fa cares were provided residents (R1) revie Findings include: R1's Admission Red R1's diagnoses incl (disabling disease of urinary tract infection of left buttock (full-th with exposed or direct tendon, ligament, car R1's re-admission M dated 3/9/21, indicar severely impaired, s assistance of two st required the use of all transfers. R1's M			Immediate Corrective Action: Resident #1 was toileted/repositio soon as issue was identified. Skin was completed with no new conce noted. NARs assigned to these re were re-educated on the need to p these services timely. Corrective Action as it applies to c The ADL Assist per Care Plan Pol reviewed and remains current. All nurses, TMAs, and NARs were re-educated on the ADL Assist pe Plan Policy specifically providing assistance with toileting/reposition resident individualized care pan. All residents needing assistance w toileting/repositioning will be provi assistance per care plan/care she details. Date of Compliance: 5/18/21	check rns sidents provide thers: cy was Care ing per <i>v</i> ith ded this	
	totally dependent or R1's Care Area Ass incontinence dated total assistance with			Recurrence will be prevented by: Audits of 5 random residents will be completed weekly x 4 then month months to assure timely assistant provided for toileting and reposition	y x 2 e is	

Facility ID: 00583

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THE WA	TERVIEW WOODS LL	с			01 GRANT AVENUE EVELETH, MN 55734		
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F 690	with cognitive impait toilet/change per plaindicated R1 require keeping skin clean to remain dry, clear R1's care plan initia incontinent of bladd be free from signs/s infection. R1's care assistance of one to and to provide assis incontinent product R1's nursing assista 4/27/21, indicated F assistance with toile reposition and toilet R1's Bladder Evalua R1 risk factors inclu assistance with all t retention of urine, u bladder, and mild co interventions includ toileting needs, help providing and assis product. R1 was to toileting program ev On 4/27/21, at 7:22 observed. R1 was so (W/C/) in her room 7:50 a.m. an unider observed entering F transport R1 via hel breakfast meal serv assistant (NA)-A was	ge 7 irment. Staff were to an of care. The CAA further ed incontinent pads to aid in and dry. Goals included for R1 h, and free from breakdown. Atted 3/10/20, indicated R1 was ler and bowel, with a goal to symptoms of urinary tract e plan directed staff to provide b two staff for toileting cares, stance with peri-cares and and to change R1 as needed. Ant care guide sheet dated R1 was incontinent, required eting, and directed staff to ther every two hours. Atton dated 3/4/21, indicated uded needing Hoyer transfers, quadriplegia, irge incontinence, overactive ognitive impairment. Current ed staff assistance with boing with peri cares and t with changing incontinence be on a check and change very 2-3 hours and as needed. a.m. R1 was continuously seated in her wheelchair in front of the television. At ntified female staff was R1's room and proceeded to r W/C to the dining room for vice. At 9:02 a.m. nursing as observed transporting R1 ining room to her room. NA-A	F	\$90	The results of these audits will be s with the facility QAPI committee for on the need to increase, decrease of discontinue the audits. Corrections will be monitored by: DON/Nurse Managers/Designee	input	

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		AND HUMAN SERVICES				FORM	05/24/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	с		601 GRANT AVENUE EVELETH, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPP FICIENCY)	BE	(X5) COMPLETION DATE
F 690	positioned R1's W/R R1's room. NA-A di was incontinent. At and stated she had morning cares were left her in her W/C further stated leavin to her buttock regio interviewed and sta repositioned every had not been reposi incontinence care s completed. NA-A s required repositioni be provided every t the cares per R1's repositioning and in important to preven On 4/27/21, at 10:1 minutes since conti registered nurse (R verified R1's inconti but that R1 had not RN-A stated staff w toileting, and provid individual care plan skin breakdown. On 4/27/21, at 2:28 (DON) was intervie expectation was for and toileted timely, were unable to corr verified R1 had a pl and stated it was ve and incontinence care	C in front of the TV and exited d not check R1 to see if she 9:51 a.m. R1 was interviewed been in her W/C since her e provided, and staff frequently for long periods of time. R1 ng her in her W/C caused pain m. At 10:04 a.m. NA-A was ted R1 should be toileted and two hours. NA-A stated R1 itioned or provided since morning cares were tated she was aware that R1 ng and incontinence cares to wo hours but had not provided care guide. NA-A stated ncontinence care was it skin breakdown. 6 a.m. (2 hours and 54 nuous observations started) N)-A entered R1's room. RN-A inent brief was wet with urine, had a bowel movement. ere to be repositioning, ling peri care per resident's to prevent new or worsening p.m. the director of nursing wed and stated her residents to be repositioned and for staff to get help if they inplete it timely. The DON ressure ulcer on her coccyx ery important that repositioning are was being provided for R1 presening or additional skin	F 69	0			

Facility ID: 00583

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		AND HUMAN SERVICES					FORM	05/24/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		X3) DATE Com	E SURVEY PLETED
		245277	B. WING _					_ 27/2021
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		-	-
THE WAT	TERVIEW WOODS LL	c			GRANT AVENUE ELETH, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD E		(X5) COMPLETION DATE
F 690	Continued From pa	nge 9	F 69	90				
	Assistance Per Car	Ionarch HealthCare ADL re Plan revised date 5/18, t residents will be checked and to care plan.						
	policy revised date	Ionarch Toileting Assistance 11/19, directed staff to provide enic, and thorough toileting						

If continuation sheet Page 10 of 10



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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.

The Waterview Woods Llc May 11, 2021 Page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

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

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

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

Minnesc	ta Department of He	alth				
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
	INTERNATO FOR DEFICIENCIES INDERVANOP CORRECTION (N) PROVIDER NUMPLIENCLIA IDENTIFICATION NUMBER: (N) INTERCATION (N) INTE		2 7/2021			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		C 601 GRAM	IT AVENUE			
			-			
PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of will corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du	ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health. The ther a violation has been compliance with all rule provided at the tag ile number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item				
	You may request a that may result fron orders provided tha the Department wit	n non-compliance with these t a written request is made to hin 15 days of receipt of a				
	On 4/26/21, through was conducted at y the Minnesota Depa facility was found N State Licensure. Pla plan of correction y and identify the date	n 4/27/21, a complaint survey our facility by surveyors from artment of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders				
ABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 05/18/21

Electronically Signed

STATE FORM

6899

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COMI	E SURVEY PLETED
		00583	B. WING			C 27/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	С	NT AVENUE I, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 000	Continued From pa	age 1	2 000			
	SUBSTANTIATED: H5277064C (MN68 issued at MN Rule Rule 4658.0525 Su H5277065C (MN70 issued at MN Rule Rule 4658.0525 Su H5277067C (MN72 issued at MN Rule Rule 4658.0525 Su The following comp SUBSTANTIATED	 (3902) with a licensing order (4658.0525 Subp. 6 B and MN) (bp. 5 A B) (0018) with a licensing order (4658.0525 Subp. 6 B and MN) (bp. 5 A B) (2026) with a licensing order (4658.0525 Subp. 6 B and MN) (bp. 5 A B) (blaints were found to be (blaints were found to be<td></td><td></td><td></td><td></td>				
	the State Licensing Federal software. T assigned to Minnes Nursing Homes. Th appears in the far-le Tag." The state stat listed in the "Summ column and replace the correction order the findings which a statute after the stat as evidence by." For are the Suggested Time Period for Co You have agreed to	participate in the electronic				
nesota D		nsure orders consistent with				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		00583			04/	27/2021
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
THE WAT	TERVIEW WOODS LL	C	H, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
	https://www.health n/infobulletins/ib14_ orders are delineate Department of Hea you electronically. is necessary for Sta enter the word "CO available for text. Ye electronic State lice heading completion be corrected prior to the Minnesota Depa is enrolled in ePOC	in 14-01, available at state.mn.us/facilities/regulatio _1.html The State licensing ed on the attached Minnesota lth orders being submitted to Although no plan of correction ate Statutes/Rules, please RRECTED" in the box ou must then indicate in the ensure process, under the n date, the date your orders wil o electronically submitting to artment of Health. The facility and therefore a signature is bottom of the first page of				
	FOURTH COLUMN "PROVIDER'S PLA	N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			5/17/21
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	B a resident w	ho has pressure sores				

STATE FORM

Y86G11

If continuation sheet 3 of 12

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		LETED
	00583		B. WING		C 04/27/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	С	NT AVENUE H, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
2 900	Continued From pa	ge 3	2 900			
		y treatment and services to revent infection, and prevent veloping.				
	by: Based on observati review, the facility f repositioning to pro	ent is not met as evidenced on, interview, and document ailed to provide timely mote healing and prevent w pressure ulcers for 1 of 3 ewed repositioning.		Date of correction: 5/17/2021		
	Findings include:					
		y stages defined by the Jlcer Advisory Panel (NPUAP)	:			
	skin with exposed of viable, pink or red, as an intact or rupto Adipose (fat) is not	njury: Partial-thickness loss of dermis. The wound bed is moist, and may also present ured serum-filled blister. visible and deeper tissues are tion tissue, slough and eschar				
	tissue loss with exp fascia, muscle, tend bone in the ulcer. S visible. Epibole (roll	njury: Full-thickness skin and losed or directly palpable don, ligament, cartilage or lough and/or eschar may be led edges), undermining en occur. Depth varies by				
	R1's diagnoses incl (disabling disease d	cord printed 4/27/21, indicated uded multiple sclerosis of the brain and spinal cord), on, and Stage 4 pressure ulcer				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00583		CONSTRUCTION	Сомі Сомі	E SURVEY PLETED C 27/2021
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
	PROVIDER OR SUPPLIER		NT AVENUE	ATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	C	H, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 4	2 900			
	3/5/21, indicated R severely impaired, s she required extens bed mobility and re use of mechanical I R1's MDS further in incontinent of blado Stage 2 and Stage	um Data Set (MDS) dated 1 indicated R1's cognition was she had no rejection of cares, sive assistance of two staff for positioning, and required the lift (Hoyer lift) for all transfers. ndicated R1 was always ler and bladder, had existing 4 pressure ulcers, and was at newly acquired pressure				
	ulcers dated 3/4/21 pressure developin Braden Scale (a too pressure ulcer deve unhealed Stage 2 a	sessment (CAA) f or pressure , indicated R1 was at risk for g ulcers according to the ol used to assist the risk of elopment), had had existing and Stage 4 pressure ulcers, developing newly acquired				
	having a pressure u immobility, with a g healing wound and R1's care plan inter provide repositionin from side to side wi directed staff to follo	ated 1/11/21, identified R1 ulcer to left buttock related to oal to be showing signs of remain free from infection. ventions directed staff to ng every two hours, turning ith pillows between knees, and ow facility protocol's for the ttment of skin breakdown.				
	4/27/21, indicated F assistance with toile	ant care guide sheet dated R1 was incontinent, required eting, and directed staff to t R1 every two hours.				
	been sent to hospit	ogress notes indicated R1 had al and was admitted for myelitis (infection spread to				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		A. B	A. BUILDING:			
		00583	B. WING		C 04/27/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
THE WA	TERVIEW WOODS LL	C	NT AVENUE H, MN 55734			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ige 5	2 900			
	had been discharge readmitted to the fa with osteomyelitis. Assessment compl readmission was a high risk for skin iss	eted at the time of 12, whcih indicated R1 was at sues/concerns. R1 was acility for hospice care with				
	observed sitting in v in front of the televi unidentified female R1's room and proc W/C to the dining r service. At 9:02 a.n was observed trans dining room to R1's W/C in front of the NA-A did not reposi interviewed and sta since her morning of frequently left her in time. R1 further sta caused pain to her NA-A was interview repositioned every had not been reposi were completed. N. R1 required reposit two hours, but had	a.m. R1 was continously wheelchair (W/C/) in her room sion. At 7:50 a.m. an staff was observed entering ceeded to transport R1 via her room for breakfast meal n. nursing assistant (NA)-A sporting R1 via W/C from the s room. NA-A positioned R1's TV and exited R1's room. ition R1. At 9:51 a.m. R1 was ted she had been in her W/C cares were provided, and staff n her W/C for long periods of ted leaving her in her W/C buttock region. At 10:04 a.m. ved and stated R1 should be two hours. NA-A stated R1 sitioned since morning cares A-A stated she was aware that ioning to be provided every not provided the cares per A-A stated repositioning was at skin breakdown.				
	minutes since conti registered nurse (R	6 a.m. (2 hours and 54 inuous observations started) N)-A entered R1's room. RN-A be repositioning residients pe				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00583		CONSTRUCTION	COMI	E SURVEY PLETED C 27/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	TERVIEW WOODS LL	601 GRA	NT AVENUE			
		EVELET	H, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	nge 6	2 900			
	or worsening skin b currently had a left completed a skin as noted to have bland right buttocks which (dissolve) with repor- the area. RN-A rem- stated R1's left butt to be doing good. F pressure ulcer was (centimeters) in len- the deepest measu pressure ulcer was with no odor noted. dressing change.	dual care plan to prevent new preakdown. RN-A verified R1 buttock pressure ulcer. RN-A ssessment on R1. R1 was chable redness to both left and h was noted to dissipate ositioning and light massage to noved R1's old dressing, and tock pressure ulcer appeared RN-A stated R1's left buttock measured at 7.2 cm ogth by 3.1 cm in width, with irrement 3.0 cm. R1's left noted to be beefy red in color RN-A completed the clean				
	(DON) was intervie expectation was for and toileted timely, were unable to com verified R1 had a p and stated it was ve and incontinence ca	p.m. the director of nursing wed and stated her r residents to be repositioned and for staff to get help if they pplete it timely. The DON ressure ulcer on her coccyx ery important that repositioning are was being provided for R1 orsening or additional skin eveloping.				
	5/13, directed staff resident's individua and to prevent skin general guidelines critical for a resider	tled Repositioning revised date to provide repositioning per I care plan to promote comfort breakdown. The policies included repositioning is nt who is immobile or aff for repositioning.				
	The Director of Nur develop, review, an	THOD OF CORRECTION: rsing (DON) or designee could id/or revise policies and ire residents do not develop a				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00583		B. WING		C 04/27/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	ADDRESS, CITY, STATE, ZIP CODE			
THE WA	TERVIEW WOODS LL	C	NT AVENUE H, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	
2 900	pressure ulcer unle and residents who receiving the prope promote healing, pr new pressure ulcer The DON or design appropriate staff or The DON or design systems to ensure	ss it is clinically unavoidable, do have pressure ulcers are r care and services needed to revent infection and promote	2 900			
2 910	Incontinence Subp. 5. Incontinent have a continuous management to reconnecessary use of comprehensive rest home must ensure A. a resident without an indwelling unless the resident that catheterization B. a resident with receives appropriate prevent urinary trace	5 Subp. 5 A.B Rehab - nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home og catheter is not catheterized 's clinical condition indicates was necessary; and ho is incontinent of bladder the treatment and services to at infections and to restore as er function as possible.	2 910		5/18/21	
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview, and document ailed to ensure incontinence d per care plan for 1 of 3		Date of Correction: 05/18/2021		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
0058		00583	B. WING	B. WING		C 27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	TERVIEW WOODS LL	C	NT AVENUE H, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 910	Continued From pa	ige 8	2 910			
	residents (R1) revie	ewed for incontinence cares				
	Findings include:					
	R1's diagnoses incl (disabling disease of urinary tract infection of left buttock (full-t with exposed or direct	cord printed 4/27/21, indicated luded multiple sclerosis of the brain and spinal cord), on, and Stage 4 pressure ulcer hickness skin and tissue loss ectly palpable fascia, muscle, artilage or bone in the ulcer).				
	dated 3/9/21, indica severely impaired, s assistance of two s required the use of all transfers. R1's M	Minimum Data Set (MDS) ated R1's cognition was she required extensive taff for bed mobility, and mechanical lift (Hoyer lift) for /IDS further indicated R1 was of bladder and bowel, and was n staff for toileting.	i			
	incontinence dated total assistance with incontinent. R1's C, with cognitive impa toilet/change per pl indicated R1 require keeping skin clean	sessment (CAA) for urinary 3/5/21, indicated R1 received h toileting and was always AA indicated R1 was alert staff irment. Staff were to an of care. The CAA further ed incontinent pads to aid in and dry. Goals included for R1 n, and free from breakdown.				
	incontinent of blade be free from signs/s infection. R1's care assistance of one to and to provide assist	ated 3/10/20, indicated R1 was der and bowel, with a goal to symptoms of urinary tract e plan directed staff to provide o two staff for toileting cares, stance with peri-cares and and to change R1 as needed.				
	R1's nursing assist	ant care guide sheet dated				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	Сом	E SURVEY PLETED C
		00583	B. WING		04/	27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	FERVIEW WOODS LL	С	NT AVENUE H, MN 55734			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 910	Continued From pa	ge 9	2 910			
	assistance with toile	R1 was incontinent, required eting, and directed staff to t her every two hours.				
	R1 risk factors inclu assistance with all t retention of urine, u bladder, and mild c interventions includ toileting needs, help	ation dated 3/4/21, indicated uded needing Hoyer transfers, quadriplegia, irge incontinence, overactive ognitive impairment. Current ed staff assistance with bing with peri cares and				
	product. R1 was to	t with changing incontinence be on a check and change /ery 2-3 hours and as needed.				
	observed. R1 was s (W/C/) in her room 7:50 a.m. an unider observed entering F transport R1 via he breakfast meal served	a.m. R1 was continuously seated in her wheelchair in front of the television. At ntified female staff was R1's room and proceeded to r W/C to the dining room for vice. At 9:02 a.m. nursing				
	via W/C from the di positioned R1's W/ R1's room. NA-A di was incontinent. At	as observed transporting R1 ining room to her room. NA-A C in front of the TV and exited d not check R1 to see if she 9:51 a.m. R1 was interviewed				
	morning cares were left her in her W/C further stated leavir	been in her W/C since her e provided, and staff frequently for long periods of time. R1 ng her in her W/C caused pain n. At 10:04 a.m. NA-A was				
	interviewed and sta repositioned every had not been repos	ted R1 should be toileted and two hours. NA-A stated R1				
	completed. NA-A s required repositioni	tated she was aware that R1 ng and incontinence cares to wo hours but had not provided	1			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	COMI	E SURVEY PLETED	
00583		00583	B. WING		04/2	/27/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
THE WA	TERVIEW WOODS LL	С	NT AVENUE H, MN 55734				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 910	Continued From pa	ge 10	2 910				
	repositioning and in important to preven	ncontinence care was It skin breakdown.					
	minutes since conti registered nurse (R verified R1's inconti but that R1 had not RN-A stated staff w toileting, and provid	6 a.m. (2 hours and 54 inuous observations started) N)-A entered R1's room. RN-A inent brief was wet with urine, had a bowel movement. rere to be repositioning, ling peri care per resident's to prevent new or worsening					
	(DON) was intervie expectation was for and toileted timely, were unable to com verified R1 had a pl and stated it was ve and incontinence ca	r residents to be repositioned and for staff to get help if they aplete it timely. The DON ressure ulcer on her coccyx ery important that repositioning are was being provided for R1 prsening or additional skin					
	Assistance Per Car	lonarch HealthCare ADL re Plan revised date 5/18, t residents will be checked and to care plan.	1				
	policy revised date	lonarch Toileting Assistance 11/19, directed staff to provide enic, and thorough toileting					
	The Director of Nur develop, review, an procedures to ensu	HOD OF CORRECTION: rsing (DON) or designee could d/or revise policies and re residents receive to prevent skin breakdown maintain dignity.					

STATEMENT OF DEFICIENCIES (X1) PRO AND PLAN OF CORRECTION IDEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00583	B. WING		C 04/27/2021
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
HE WAT	ERVIEW WOODS LL	C	NT AVENUE H, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE
2 910	Continued From pa	ige 11	2 910		
	appropriate staff or The DON or design	nee could educate all in the policies and procedures. nee could develop monitoring ongoing compliance.			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one			