DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 28, 2022

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

RE: CCN: 245277
Cycle Start Date: August 16, 2022

Dear Administrator:

On September 15, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
August 29, 2022

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

RE: CCN: 245277
Cycle Start Date: August 16, 2022

Dear Administrator:

On August 16, 2022, 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"and/or an E tag), i.e., the plan of correction should be directed to:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 November 16, 2022 (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 February 16, 2023 (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, Compliance Analyst
Minnesota Department of Health
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 08/16/2022

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 8/15/22, to 8/16/22, 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 complaint was found to be SUBSTANTIATED: H52773952C(MN00085903), with deficiencies cited at F684. 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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 684	F684: Quality of Care	9/7/22

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

Electronically Signed | 09/01/2022

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 684	Continued From page 1 review the facility failed to follow orders for daily dressing changes as written by the provider for 2 of 3 residents (R1, R3), and with appropriate barrier protection for 1 of 3 (R1) reviewed for quality of care related to wounds. Findings include: R1's Facesheet printed 8/16/22, indicated diagnoses of, non-pressure chronic ulcer of the right foot and peripheral vascular disease. R1's care plan dated 8/16/22, indicated a risk for skin breakdown related to vascular and diabetes diagnoses and history of pressure wounds. Interventions for care plan included surgical wound dressings would be changed by nursing per the provider order, and also R1 was followed by wound care team. R1's Integrated Wound Care (IWC) follow-up progress note dated 8/11/22, indicated there was a concern about maggots which were seen with the last dressing change to the dorsal right foot vascular ulcer. Orders included wound cleanser, Dakins wet to dry dressing daily, secured with elastic gauze then the wound would be wrapped and taped. R1's treatment assessment report (TAR) printed 8/16/22, indicated orders for right dorsal foot wound had to be changed daily on the evening shift. The TAR lacked wound care documentation for 7/8/22, 7/11/22, 7/17/22,7/22/22, 7/25/22, 8/9/22 and 8/14/22. On 8/16/22, at 2:08 p.m. registered nurse (RN)-A was observed entering R1's room to perform his dressing change. R1 was observed sitting in his	F 684	Immediate Corrective Action: R1's and R3's wound treatments were completed per MD order. Action as it Applies to Others: Skin Assessment & Wound Management policy was reviewed and remains current. All residents with wounds were assessed to ensure that wound care treatments were being completed at the frequency and with the dressings/treatments specified in provider order. All nurses educated on need to complete wound treatments at the frequency and with the dressings/treatments specified in provider order. They were also educated having a barrier between wound and surface such as if wound were on bottom of foot and touching ground. Nurses were also educated on need to document if resident refuses the treatment per orders and to notify Administrator or DON if a wound treatment was not able to be completed d/t running out of time. Date of Compliance: 9/7/2022 Reoccurrence will be prevented by: Audit of 5 residents with wounds will be conducted weekly x 4 weeks then monthly x2 months to assure wound care treatments is being completed per MD order. 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 684	Continued From page 2 recliner, with his feet on the floor, when RN-A entered room RN-A washed her hands with soap and water, placed nonsterile gloves on her hands and removed the soiled dressing from R1's right foot while R1 held his foot up off the floor. After the old dressing was removed, and prior to the new dressing, the right foot was placed directly on the floor without placing a barrier between the foot and the floor first. RN-A removed her soiled gloves, washed her hands, placed clean nonsterile gloves back on her hands and gathered the new dressing change items. The following wound care items were observed being gathered: sterile abdominal (ABD) pad, non-sterile elastic gauze and non-sterile 4x4 gauze pad. the 4x4 gauze pad was saturated with Dakins solution and placed into the wound utilizing nonsterile gloves. The sterile ABD pad was removed from the package and placed over the wound and then wrapped with elastic gauze and secured with tape. Two flies were observed flying around room while dressing was changed. On 8/15/22, at 2:31 p.m. the IWC certified nurse practitioner (CNP) stated she had been seeing R1 for reoccurring vascular ulcers "off and on" for two years. The CNP was made aware of maggots on R1's wounds when she entered the facility to start her visits. CNP stated R1 was not on any kind of maggot therapy orders and had never been on maggot therapy for his wounds. CNP stated the facility had black flies in the building and the maggots were caused by fly eggs laid on the wound or dressing material. The CNP stated missed dressing changes could increase the risk of maggots when an environment had flies. The CNP stated her expectation was dressings would be changed as they were ordered.	F 684		

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F 684	Continued From page 3 On 8/16/22, at 11:33 a.m. licensed practical nurse (LPN)-A stated when she performed R1's dressing change on 8/10/22, the dressing was saturated with drainage and the sheet where the foot was had dried drainage on it. The dried drainage on the dressing and sheet was not orange so it had been there awhile. LPN-A stated as she removed the dressing she saw multiple white maggots on the dressing and then on the wound. LPN-A stated the dressing did not have a time or date on it so she could not tell if the dressing had been changed the day before. LPN-A stated she looked at the charting and nothing was entered under the TAR for 8/9/22, for dressing change. LPN-A stated the orders were for daily dressing changes. LPN-A stated once the dressing was changed the nurse manager was notified. LPN-A stated there were a lot of flies in the facility and R1's room over the last couple of weeks. On 8/16/22, at 12:11 p.m. LPN-C stated dressing changes that could not be done on the shift were to be left blank in the TAR and reported off to next shift so next shift could complete. LPN-C stated she was the nurse working evening shift on 8/9/22, and she was the only nurse in the building at six p.m. LPN-C stated she did not get R1's dressing change done that evening because of staffing issues and problems with another resident. LPN-C stated the night was "crazy" and she forgot to pass on that the dressing had not been changed. LPN-C stated she should have passed on this information so it could have been done by the next shift. On 8/16/22, at 2:25 p.m. registered nurse (RN)-A stated she was made aware of the maggots on R1's wound on 8/10/22. RN-A stated she notified	F 684		

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F 684	Continued From page 4 the provider and the wound care nurse practitioner. RN-A stated R1's dressing change orders included the use of Dakins solution packing into wound daily. RN-A stated Dakins solution was used when a wound has increased drainage. RN-A stated all dressing changes were documented in the TAR after they were completed; and if not completed the TAR would be left empty and reported to next shift to complete. RN-A stated if TAR entry was empty they would not know if the dressing change was done or not. RN-A reviewed the TAR for 8/9/22, and confirmed there was no entry documented for that day. RN-A stated she did not know a lot about maggots but did "believe" that dressing changes missed would increase risk of infection and maggots when flies were around. RN-A stated there should have been a barrier between the floor and foot after the dressing was removed from R1's right foot. RN-A stated the barrier on the floor would decrease the risk R1 would have further infection control issues, or maggots reappearing. RN-A stated her expectation was nursing staff would follow doctor's orders for dressing changes. On 8/16/22, at 3:02 p.m. RN-B stated an expectation nursing would follow provider orders and perform as directed. RN-B also stated exposed wounds on feet should not be placed on the ground without a barrier. RN-B stated an open wound on a foot placed on the ground without a barrier increased the risk of infection and complications to the wound. The facility policy Dressing, Dry/Clean dated 2013, indicated preparation included the provider order would be verified. The policy indicated nursing should notify supervisor if the resident	F 684		

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F 684	Continued From page 5 refused dressing change. The policy lacked direction if nursing would miss an ordered dressing change. The facility policy also indicated the first step was to establish a clean field. The policy lacked any information in regard to a dressing changed on the floor without a barrier. R3 R3's Facesheet printed 8/16/22, indicated diagnoses of peripheral vascular disease, varicose veins of left lower extremity with ulcer of ankle and non-pressure chronic ulcer of unspecified part of lower leg with unspecified severity. R3's progress note dated 8/2/22, at 11:42 a.m. indicated R3's "memory recall was intact". R3's care plan dated 8/2/22, indicated an alteration in skin integrity related to vascular ulcers to bilateral legs present upon admission. Interventions included treatment to open areas per orders and followed by wound care. R3's Integrated Wound Care (IWC) follow up progress note dated 8/11/22, indicated orders to clean wound with wound cleanser, nursing would place Mepilex AG, a dressing used to treat wounds with low to medium amount of drainage, trimmed to the size of the wound over the wound. Nursing would then wrap with elastic gauze and secure with tape. Tubigrips, a tube like mess bandage that is slid up the inteneded body part to provide light compression to area, were to be placed on R3's legs daily from the toes to the knees. Lastly, nursing was to change Mepilex AG every other day.	F 684		

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F 684	Continued From page 6 During observations on 8/15/22, at 2:31 p.m. R3 did not have his tubi grips on either leg or foot. R3 had on elastic gauze wrapped over some other dressing and secured with tape. During observations on 8/16/22, at 10:16 a.m. R3 was observed laying on his bed without tubi grips on. During observations on 8/16/22, at 1:35 p.m. R3 did not have his tubigrips on either leg. On 8/15/22, at 2:31 p.m. R3 stated he was in the facility for rehabilitation services. R3 stated he had the wounds prior to admission. R3 stated he would do the dressing changes himself at home, but now he couldn't and that was why he was admitted to facility. R3 stated he would need assistance to get his "special socks" on and off. R3 pointed to his leg dressings and stated the dressings he had on were what the nursing staff would place on him. On 8/16/22, at 2:25 p.m. RN-A entered R3's room and stated R3 did not have his tubi grips on as ordered by provider. RN-A stated the tubi grips are ordered to assist in circulation to promote wound healing and should be on. RN-A stated she did not know why the tubi grips were not on. RN-A stated her expectation was nursing would follow providers orders as written. On 8/16/22, at 2:54 p.m. LPN-B stated she was not sure if R3 had orders for Tubigrips. LPN-B state R3 wore tubi grips all of the time and never took them off. LPN-B stated she performed R3's dressing change frequently, and she would take the tubi grips off for the dressing change and then	F 684		

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F 684	Continued From page 7 would put them back on right away. During interview on 8/16/22, at 3:10 p.m. the administrator stated there was an expectation all nursing staff follow the policy and procedures to decrease the risk of infection to any open wounds. Facility policy for following orders was requested but not provided.	F 684		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 29, 2022

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

Re: Event ID: 9DP211

Dear Administrator:

The above facility survey was completed on August 16, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/15/22, to 8/16/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.	2 000		

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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
2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H52773952C(MN00085903), however NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		