

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email October 9, 2020

Administrator The Waterview Pines Llc 1201 8th Street South Virginia, MN 55792

RE: CCN: 245283 Cycle Start Date: July 29, 2020

Dear Administrator:

On October 5, 2020, 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,

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 18, 2020

Administrator The Waterview Pines LLC 1201 8th Street South Virginia, MN 55792

RE: CCN: 245283 Cycle Start Date: July 29, 2020

Dear Administrator:

On July 29, 2020, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Teresa Ament, Unit Supervisor Email: teresa.ament@state.mn.us Phone: (218) 302-6151 Fax: (218) 723-2359

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 October 29, 2020 (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 January 29, 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.

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					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			(<u> </u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CON	TE SURVEY MPLETED
		245283	B. WING				C / 29/2020
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		12312020
THE WAT	ERVIEW PINES LLC				201 8TH STREET SOUTH RGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	FC	000			
	was completed at y complaint investiga not to be in complia Requirements for L The following comp substantiated: H52 H5283027C, H5283 The facility's plan of as your allegation o Department's accep enrolled in ePOC, y at the bottom of the	29/29, an abbreviated survey our facility to conduct a tion. Your facility was found ance with 42 CFR Part 483, ong Term Care Facilities. Alaints were found to be 283025C, H5238026C, 3028C, and H5283029C. If correction (POC) will serve of compliance upon the potance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 686 SS=D	on-site revisit of you validate that substa regulations has bee your verification. Treatment/Svcs to l	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with Prevent/Heal Pressure Ulcer 1)(i)(ii)	F6	86			8/31/20
	resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that t (ii) A resident with p	sure ulcers. rehensive assessment of a					
		ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						08/26/2020

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: 09/16/2020

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/16/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245283	B. WING			(07/2	29/2020
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE WAT	ERVIEW PINES LLC				01 8TH STREET SOUTH RGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	promote healing, pr new ulcers from der This REQUIREMEN by: Based on observat review, the facility fa and off-loading of p plan to prevent deve for 1 of 3 residents repositioning. Findings include: R1's Admission Rec R1's diagnoses incl hemiparesis followin (weakness or paraly following a stroke), cognitive functions posture, neuralgia a contracture of hand tendons, or ligamen movement of the af R1's quarterly Minin 5/4/20, indicated R1 cognitive skills for d rejection of care be assist of two staff for two staff for transfe staff for toileting car incontinent of bowe R1 had no pressure reducing device in of R1's quarterly review	andards of practice, to event infection and prevent veloping. IT is not met as evidenced ion, interview, and document ailed to ensure repositioning ressure according to the care elopment of pressure ulcers (R1) reviewed for cord printed 7/30/20, indicated uded hemiplegia and ng cerebral infarction vsis on one side of body signs and symptoms involving and awareness, abnormal ind neuritis (nerve pain), and (fixed tightening of muscle, its that prevents normal fected body part). num Data Set (MDS) dated had moderately impaired aily decision making, had no naviors, required extensive or bed mobility, total assist of rs, extensive assist of one res, and was always I. R1's MDS further indicated e ulcers, and had a pressure chair and bed.	F 6	886	F686 Treatment/Svcs to Prevent/He Pressure Ulcer Immediate Corrective Action: Resident #1 □s care plan, group she and Kardex was updated with individualized repositioning needs. Corrective Action as it applies to oth The Policy and Procedure for Skin Assessment and Wound Manageme remains current. All licensed nurses and NARs will be re-educated on the need to refer to sheets/Kardex for individualized repositioning programs by 8/31/2020 All residents will be reviewed to ensi- that their repositioning needs are indicated on the CNA group sheets are they are independent. Care plans ar Kardex □s were updated as well. Date of Compliance: 8/31/2020. Recurrence will be prevented by: Audits of 5 residents □ repositioning will be conducted 3x/week x 4, 2x/w 4, and then weekly x 4 to assure this practice is still appropriate. The res 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/ADON/Nurse Managers/Desig	eet, ers: ent group 0. ure unless nd plans /eek x sults	
		Braden Scale assessment ermining risk of skin					

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		AND HUMAN SERVICES				FORM	09/16/2020 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245283	B. WING				C 29/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
THE WA	TERVIEW PINES LLC				1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	breakdown) had be determination was in skin breakdown. R ² indicated R1 had the (partial thickness lo dermis presenting a red pink wound becompresent as an intact blister) to the outsice from resting on the interventions had be notes additionally in and repositioned eve bowel incontinence R1's care plan revie was at risk for skin mobility and bowel current pressure inj R1's care plan furth incontinent of bowe assistance of with p lacked directives for repositioning, and co breakdown. R1's Kardex/care g indicated R1 require bed mobility and tra elimination needs a group sheets lacked and off-loading R1. On 7/28/20, from 3: continuous observation off-loaded or signifi seated in his wheel any time was appro-	en completed, and made that R1 was at risk for I's progress notes further ree Stage 2 pressure injuries	F	586			

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		AND HUMAN SERVICES				FORM	09/16/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245283	B. WING				C 29/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE WAT	TERVIEW PINES LLC				201 8TH STREET SOUTH /IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From pa	ige 3 and wash up R1 before	F 6	86			
	transferring R1 to b R1 was transferred movement from R1	to bed, NA-E washed bowel 's rectal area and buttocks. on of skin breakdown on his					
	to be repositioned e resident asks more repositioning inform sheets. NA-I stated	p.m. NA-I stated everyone is every 2 hours, unless the frequently. NA-I stated the nation is not on the group she usually repositions and en she starts her shift, before nner.					
	not been reposition since she started h stated R1 was alrea usually was in bed, up, he was repositio was already up, he off-loaded. NA-E s repositioned every 2	p.m. NA-E verified R1 had ed or checked and changed er shift at 2:30 p.m. NA-E ady up when she started, and so when she would get him oned at that time. Since R1 did not get repositioned or tated R1 should be 2 hours, and verified R1 did d in 2 hours on this date.					
		p.m. NA-A stated R1 required h cares, including toileting and					
	verified R1 was to b and was at risk for a repositioned timely. lacked direction for	p.m. registered nurse (RN)-A be repositioned every 2 hours, skin breakdown when not . RN-A verified R1's Kardex repositioning R1, but said ne is every 2 hours.					
	On 7/20/20, at 4:00 (DON) stated there	p.m. the director of nursing should have been					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE SURVEY
IND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED
		245283	B. WING		07/29/2020
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
THE WA	TERVIEW PINES LLC			1201 8TH STREET SOUTH VIRGINIA, MN 55792	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE
F 686	communication with got out of bed so st The DON verified F breakdown. The DO repositioned in his of pressure, and did a was not complete of The facility policy S Management dated and care lists be up	ige 4 In shift change as to when R1 aff could reposition him timely. R1 was at risk for skin DN stated R could be chair to re-distribute the cknowledge re-distribution off-loading of pressure. kin Assessment and Wound I 7/18, directed the care plan odated with new skin concerns, according to nursing or	F 686		
F 688 SS=E	CFR(s): 483.25(c)(§483.25(c) Mobility §483.25(c)(1) The f resident who enters range of motion do range of motion unl condition demonstr of motion is unavoid §483.25(c)(2) A res motion receives ap services to increase prevent further dec §483.25(c)(3) A res receives appropriat assistance to maint the maximum pract	acility must ensure that a s the facility without limited es not experience reduction in less the resident's clinical ates that a reduction in range	F 688	3	8/31/20

Facility ID: 00582

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUU	ווחו	E CONSTRUCTION		0938-039 SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
							2
		245283	B. WING			07/2	29/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE WA	TERVIEW PINES LLC				201 8TH STREET SOUTH IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 688	Continued From pa	ige 5	F 6	88			
	of restorative programs in planned programs in R4, and R6) review Findings include: R1 R1's Admission Rea R1's diagnoses incl hemiparesis following (weakness or paral following a stroke), cognitive functions posture, neuralgia a contracture of hand tendons, or ligamer movement of the ad R1's quarterly Minir assessment dated moderately impaire decision making, ha behaviors, and had 15 minutes over the range of motion wa assessment. R1's Restorative Ne Group POC (plan of indicated R1 was to (PROM) to all joint times weekly, and of was changed to see R1's Restorative Ne Group POC, initiated	ams according to the care for 4 of 4 residents (R1, R2, red for restorative programs. cord printed 7/30/20, indicated luded hemiplegia and ng cerebral infarction ysis on one side of body signs and symptoms involving and awareness, abnormal and neuritis (nerve pain), and d (fixed tightening of muscle, hts that prevents normal ffected body part). mum Data Set (MDS) 5/4/20, indicated R1 had d cognitive skills for daily ad no rejection of care no restorative programs for e assessment period. R1's is not assessed on this ursing Program/Wellness of care), initiated 6/2/14, o have passive range of motion of left upper extremity five on 10/17/14, left hand PROM			Immediate Corrective Action: Resident #1, #2, #4, and #6 s rest programs were reviewed for contin appropriateness of program. Corrective Action as it applies to ot The Policy and Procedure for Resid Mobility and Range of Motion rema- current. All NARs will be re-educated on completing restorative exercises, a as ensuring appropriate documenta the exercises by 8/31/2020. The restorative program of each re- will be reviewed monthly by a licens nurse for continued monitoring of g participation, and possibility of alter of program. This meeting will be documented in medical record. Date of Compliance: 8/31/2020. Recurrence will be prevented by: Audits of 5 residents restorative programs will be conducted 3x/wee 2x/week x 4, and then weekly x 4 to ensure programs are completed ar documented. The results will be st with the facility QAPI committee for on the need to increase, decrease discontinue the audits. Corrections will be monitored by: DON/ADON/Nurse Managers/Desi	ued hers: dent ins s well ation of sident sed oals, ration ek x 4, o hared input or	

Facility ID: 00582

If continuation sheet Page 6 of 27

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245283	B. WING				C 29/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WAT	ERVIEW PINES LLC				1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	A review of R1's resindicated R1 was to left, replace splint a weekly, and monito times weekly right u addition, R1 was to bilateral lower extree to allow feet to be fil restorative docume following: - From 5/11/20 to 5/ completed 2 of 3 op -From 5/18/20 to 5/ completed 3 of 3 op - From 5/25/20 to 5 programs were con extremity programs opportunities. -Documentation for not provided. -From 6/8/20 to 6/1 completed 3 of 3 op -From 6/15/20 to 6/ completed 3 of 3 op -From 6/22/20 to 6/ completed on uppe opportunities, and f were completed 2 of -From 6/29/20 to 7/ completed on uppe opportunities, and f were completed 2 of -From 7/6/20, to 7/1	mps, three times weekly. storative documentation have PROM to all joints on fter hand ROM three times r splint as needed, and five upper extremity PROM. In have three times weekly mity PROM/ assisted AROM at on the pedals. R1's ntation further indicated the (17/20, R1's programs were oportunities. 24/20, R1's programs were oportunities. (31/20, R1's upper extremity npleted 4 days and lower were completed 2 of 3 week of 6/1/20 to 6/7/20, was 4/20, R1's programs were oportunities. 21/20, R1's programs were oportunities. 21/20, R1's programs were r extremities 3 of 3 or lower extremities, programs of 3 opportunities. 2/20, R1's programs were r extremities 3 of 3 or lower extremities, programs of 3 opportunities. 2/20, R1's programs on upper	F 6	88			
	and for lower extrem completed 1 of 3 op	mpleted 2 of 3 opportunities, nities, programs were oportunities. /19/20, R1's programs were					

Facility ID: 00582

If continuation sheet Page 7 of 27

PRINTED: 09/16/2020

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	09/16/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	0	(X3) DATI COM	E SURVEY PLETED
		245283	B. WING	i				C 29/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE,	ZIP CODE		
THE WA	TERVIEW PINES LLC				201 8TH STREET SOUTH /IRGINIA, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 688	Continued From pa completed 1 of 3 or	•	F	688				
		/26/20, R1's programs were portunities						
	assistant (NA)-J inc treatments and did NA-J documented k not available when	storative aide/nursing licated R1 did not refuse restorative programs well. blank boxes indicated R1 was approached for therapy or ative aide working that day.						
	R2							
	R2's diagnoses incl	cord printed 7/29/20, indicated uded dementia with nce, muscle weakness, and						
	had a severe cognit assistance with bed ambulation on the u	dated 4/28/20, indicated R1 tive deficit, required extensive mobility, transfers and unit. R1's MDS further prestorative programs.						
	staff to ambulate R able, with one staff push the wheelchai	ewed 7/22/20, directed nursing 2 two to three times daily as to walk with R2 and one to r behind R2. If R2 refused re-approached at a later time aily.						
	1/10/11, indicated R following: AROM/PI hand exercises three Restorative Service indicated R2 was to	ervices Plan of Care dated 22 was to have 3 of the ROM, upper extremity and the times weekly. Another Plan of Care dated 3/22/11, have other exercises on the times weekly. A third						

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/16/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
		245283	B. WING	i			C 29/2020
NAME OF F	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
	TERVIEW PINES LLC			·	1201 8TH STREET SOUTH		
	ERVIEW PINES LLC			· ۱	VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	Restorative Service 12/14/18, indicated exercises three time A review of R2's res indicated R2 was to AROM, and exercise weekly. In addition exercises three time extremity exercises R2's restorative door following: - From 5/11/20 to 5/ completed 1 of 3 op -From 5/18/20 to 5/ completed 0 of 3 op those days, and wa - From 5/25/20 to 5/ completed 2 of 3 op the third opportunity -Documentation for not provided. -From 6/8/20 to 6/1 completed 1 of 3 op days after 3-4 appro -From 6/15/20 to 6/1 was completed 1 of refused 2 days with one day. -From 6/22/20 to 6// completed 1 of 3 op two other days. -From 6/29/20 to 7// completed 1 of 3 op two other days. -From 6/29/20 to 7// completed 1 of 3 op two other days.	A provide the second se	F	688	3		

If continuation sheet Page 9 of 27

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC 245283 (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL STREET ADDRESS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX	PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391		AND HUMAN SERVICES & MEDICAID SERVICES		
245283 B. WING O7/29/202 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH THE WATERVIEW PINES LLC 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) (xx) (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (xx) (CACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 688 Continued From page 9 (CROSS-REFERENCED TO THE APPROPRIATE ACTION TO THE APPROPRIATE (CROSS-REFERENCED TO THE APPROPRIATE (CROSS-REFERENCE	LE CONSTRUCTION (X3) DATE SURVEY COMPLETED	. ,	(X1) PROVIDER/SUPPLIER/CLIA	ENT OF DEFICIENCIES	STATEMENT
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792 (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-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMPL COMPL CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) F 688 Continued From page 9 R2's refusals on those dates. - From 7/13/20 to 7/19/20, R2's program documentation was blank 2 of 3 days and zeros a third day. 7/15 - From 7/20/20 to 7/26/20, R2's ROM was completed 2 of 3 opportunities and a line drawn through a third day. 7/20, 7/25 F 688 In addition, R2 had an ambulation program to be completed and documented by nursing, which In addition, R2 had an ambulation program to be	07/29/2020	3. WING	245283		
THE WATERVIEW PINES LLC VIRGINIA, MN 55792 (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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPL COMPL COMPL DATE F 688 Continued From page 9 R2's refusals on those dates. - From 7/13/20 to 7/19/20, R2's program documentation was blank 2 of 3 days and zeros a third day. 7/15 - From 7/20/20 to 7/26/20, R2's ROM was completed 2 of 3 opportunities and a line drawn through a third day. 7/20, 7/25 F 688 In addition, R2 had an ambulation program to be completed and documented by nursing, which In addition, R2 had an ambulation program to be	•	5		OF PROVIDER OR SUPPLIER	NAME OF F
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPL DATE F 688 Continued From page 9 R2's refusals on those dates. - From 7/13/20 to 7/19/20, R2's program documentation was blank 2 of 3 days and zeros a third day. 7/15 - From 7/20/20 to 7/26/20, R2's ROM was completed 2 of 3 opportunities and a line drawn through a third day. 7/20, 7/25 F 688 In addition, R2 had an ambulation program to be completed and documented by nursing, which In addition, R2 had an ambulation program to be				VATERVIEW PINES LLC	THE WAT
R2's refusals on those dates. - From 7/13/20 to 7/19/20, R2's program documentation was blank 2 of 3 days and zeros a third day. 7/15 - From 7/20/20 to 7/26/20, R2's ROM was completed 2 of 3 opportunities and a line drawn through a third day. 7/20, 7/25 In addition, R2 had an ambulation program to be completed and documented by nursing, which	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	PREFIX	MUST BE PRECEDED BY FULL	X (EACH DEFICIENC)	PRÉFIX
 with a wheelchair pulled behind for safety and assist of 2. R2's Documentation on the Plan of Care Response History report for the month of July, indicated R2's ambulation is recorded. R2's ambulation is also recorded in Tasks. A review of both documents for the month of July/2020, revealed R2 either ambulated or was offered ambulation and refused less than 3 times daily 5 of 28 days. On 7/28/20, at 5:00 p.m. two different staff were observed to offer ambulation with R2, who refused both times. On 7/28/20, at 7:02 p.m. R2 was observed to walk in the corridor with two staff assist according to her care plan. On 7/29/20, at 9:47 a.m. NA-B stated the restorative aide who did restorative programs and the nursing assistants did not do restorative programs and the nursing assistants did not do restorative programs and the NA's do not do them. 		F 688	 bese dates. /19/20, R2's program blank 2 of 3 days and zeros a /26/20, R2's ROM was poportunities and a line drawn 7/20, 7/25 an ambulation program to be umented by nursing, which a ambulate three times daily ulled behind for safety and n on the Plan of Care eport for the month of July, ulation is recorded. R2's recorded in Tasks. A review for the month of July/2020, ambulated or was offered used less than 3 times daily 5 p.m. two different staff were mbulation with R2, who p.m. R2 was observed to with two staff assist according a.m. NA-B stated the o did restorative programs and the prestorative programs and the progr	 R2's refusals on the - From 7/13/20 to 7 documentation was third day. 7/15 - From 7/20/20 to 7 completed 2 of 3 op through a third day. In addition, R2 had completed and doc indicated R2 was to with a wheelchair p assist of 2. R2's Documentation Response History r indicated R2's amb ambulation is also r of both documents revealed R2 either ambulation and refused both times. On 7/28/20, at 5:00 observed to offer an refused both times. On 7/28/20, at 7:02 walk in the corridor to her care plan. On 7/29/20, at 9:47 restorative aide whethe nursing assistation programs. On 7/29/20, at 9:55 restorative aides dot 	F 688

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	-	AND HUMAN SERVICES & MEDICAID SERVICES					FORM	09/16/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	·	PLE CONSTF G		0	(X3) DATE COM	E SURVEY PLETED
		245283	B. WING _					C 29/2020
NAME OF F	PROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP	CODE		
THE WAT	ERVIEW PINES LLC				STREET SOUTH , MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CC ACH CORRECTIVE ACTIO DSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 688	Continued From pa	ge 10	F 68	8				
	stated R1 did not al left leg, and she rep stated R1 does RO right leg fine, and is stated when clients another sheet. On 7/29/20, at 11:42 (DON) stated the re to work on the unit, have a restorative a been in transition w DON stated if a res restorative program	4 a.m. restorative aide/NA-C low them to do ROM of the ported that to nursing. NA-C M programs on hands and a usually compliant. NA-C refuse, they document on 2 a.m. the director of nursing estorative aide is never pulled but sometimes they do not aide. The DON stated they had ith new restorative aides. The ident misses a day of as, it should be made up						
	stated the nursing a ambulation if the re- working that day. F passive ROM. RN- ROM of his left lowe ulcers. RN-A verifie for the nursing assis he probably had no restorative aides we would have a poten On 7/29/20, at 2:50 have restorative me them. The DON sta status and any char stiffness or a declin orders. The DON sta	p.m. registered nurse (RN)-A assistants would do ROM, or storative aides were not RN-A stated they would do the A verified R1 was not allowing er extremity due to pressure d R1 did not have a signs off stants to do ROM, so stated t gotten ROM when the ere not there, and therefore tial for a decline in ROM. p.m. the DON stated they betings, but do not document the they discussed residents' nges, such as increased e, and then would get therapy tated there were no notes on dicate there was a change in						

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		AND HUMAN SERVICES				FORM	09/16/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245283	B. WING				C 29/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE WAT	TERVIEW PINES LLC				201 8TH STREET SOUTH /IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	On 7/29/20, at 3:22 when a resident has because it pops up they document "not On 7/29/20, at 4:08 have tried different restorative and for F documentation tool so many different w makes it more diffic track. The DON sta	ige 11 c.p.m. NA-K stated they know s a restorative program on the computer. NA-K stated t applicable" if it was not done. c.p.m. the DON stated they ways of documenting R2, the family has a for ambulation, also. Having vays and places to document cult for staff and difficult to ated restorative programs esident's care plans.	F	\$88			
	R4's diagnoses incl behavioral disturbat R4's annual MDS d severely impaired c identified R4 did no	cord dated 7/29/20, indicated luded dementia without nce and muscle weakness. lated 5/5/20, identified R4' had cognition. The MDS further it walk, and had not rejected of					
	R4's care plan date unable to ambulate	en day look-back period ed 8/12/19 indicated R4 was e safely due to osteoarthritis ess. The care plan directed e (walk).					
	Restorative Service	munication to Wellness / es document dated 12/21/26, ambulation was to be					
	indicated R4 was to	torative documentation be ambulated six times ative documentation further					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	PLE CONSTRUCTION	1	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	3		PLETED
		245283	B. WING	-			C 29/2020
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC				1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	indicated - From 5/11/20 to 5, of six opportunities. - From 5/25/20 to 5 four of six opportun - From 7/13/20 to 7 of six opportunities. - From 7/20/20 to 7 of six opportunities. - No refusals were of R6 R6's Admission Rec R6's Admission Rec R6's annual MDS d BIMS score was 14 cognition. R6's MD not rejected care. R6's Restorative Se 6/24/19, indicated F stretches to her har contractures. The s performed three tim Review of R6's rest indicated R6 was to her lower extremities restorative docume - From 5/11/20 to 5, performed one of th - From 6/29/20 to 7 performed one of th - From 6/29/20 to 7	 /17/20, R4 was ambulated two /31/20, R4 was ambulated ities. /19/20, R4 was ambulated two /26/20, R4 was ambulated five documented. cord dated 7/29/20, indicated uded osteoporosis and ated 6/26/20, identified R6's which indicated intact S further identified she had ervices Plan of Care dated R6 was to be provided gentle mstrings and ankles related to stretches were to be hes weekly. orative documentation have stretching performed to be sthree times weekly. The intation further indicated: (17/20, R6's stretching was irree opportunities. (31/20, R6's stretching was irree opportunities. (5/20, R6's stretching was 	F 6	\$88			

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	-	AND HUMAN SERVICES					FORM	APPROVED
	COF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TID	PLE CONSTRUCTION			0938-0391 E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	ì í		G	(.		PLETED
			The BOILD		~		(C
		245283	B. WING					29/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
	TERVIEW PINES LLC				1201 8TH STREET SOUTH			
					VIRGINIA, MN 55792			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC		_	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR			COMPLETION DATE
		,			DEFICIENCY)			
			1					
F 688	Continued From pa	ge 13	F 6	888	3			
	not performed.							
	- No refusals were	documented.						
	On 7/20/20 at 11.4	5 a.m., R4's restorative						
		reviewed with nursing						
	assistant (NA)-C. N	0						
		ted which indicated R4						
		and stated "she probably						
		NA-C stated there were two cently hired. NA-C stated she						
		formed restorative cares						
		des were not scheduled.						
		8 p.m. an interview was DON. The DON stated						
		d residents when restorative						
	0	eduled. The DON stated lists						
		h nurses' station so staff knew						
		eded to get walked. The DON						
		ot allowed to perform						
		vere not trained by therapy. storative aides were						
		wever, there may be a day in						
		scheduled due to training. The						
		ocumented refusals on therapy						
		e DON stated if no progress						
		likely a resident did not refuse						
	care.							
	On 7/29/20, at 12:2	6 p.m. an interview was						
	conducted with RN-	B. RN-B stated nursing staff						
		ve cares when restorative						
		lable. RN-B stated nursing tle stretching and walked						
		ated nursing staff documented						
		e walked, but not stretched.						
		p.m. an interview was DON. The DON stated two						

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		AND HUMAN SERVICES				FORM	09/16/2020 APPROVED 0938-0391
STATEMENT OF DE AND PLAN OF COR	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE COMI	E SURVEY PLETED
		245283	B. WING			C 07/29/2020	
NAME OF PROVID	ER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	·	
THE WATERVI	EW PINES LLC				201 8TH STREET SOUTH /IRGINIA, MN 55792		
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
On 7 cond was restd docu confi R4 n On 7 cond man indic prog prog feet. mad com walk restd the r On 7 cond man indic prog prog feet. mad com valk restd the r	ed. 7/29/20, at 3:08 Jucted with NA- at the nurses's prative cares ne ment was revie rmed the restored eeded to be war 7/29/20, at 3:08 Jucted with NA- ager placed a lated which res rams. NA-H st ram and she us NA-H was asle e aware when a pleted. NA-H st ram and she us NA-H was asle e aware when a pleted. NA-H st ram and she us NA-H was asle e aware when a pleted. NA-H st ram and she us NA-H was asle e aware when a pleted. NA-H st ram and she us NA-H was asle e aware when a pleted. NA-H st ram and she us NA-H was asle e aware when a pleted. NA-H st ram and she us NA-H was asle e aware when a pleted. NA-H st ram and she us NA-H st ram and she us ram	 signed when COVID-19 p.m. an interview was F. NA-F stated a document station which indicated what beded to be completed. The ewed, with NA-F and NA-F arative sheet lacked indication alked. p.m. an interview was H. NA-H stated the unit ist at the nurses' station which idents were on restorative tated R4 was on a walking sually ambulated five to 15 ked how nursing staff was restorative cares were not stated staff assumed R4's j done. NA-H stated the bocumentation was locked in e afterhours. p.m. an interview was DON. The DON stated the rogram was a work ON stated she recently started gram and there wasn't a good p.m. an interview was DON. The DON stated staff onlow resident restorative he DON stated she needed to see what R6's restorative book stated she needed to see what R6's restorative book stated she did not know ed restorative cares, but had 	F	\$88			

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245283	B. WING _			C 29/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WAT	ERVIEW PINES LLC			1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	Continued From pa	ge 15	F 68	38		
F 690 SS=D	Motion dated 7/17, limited range of mor services to increase decrease in ROM." "Residents with limi appropriate services to maintain or impro- in mobility is unavoi Bowel/Bladder Inco CFR(s): 483.25(e)(1) §483.25(e)(1) The f resident who is com	ntinence, Catheter, UTI 1)-(3) ence. facility must ensure that tinent of bladder and bowel on	F 69	90		8/31/20
	maintain continence condition is or beco not possible to mair	services and assistance to e unless his or her clinical mes such that continence is ntain. resident with urinary				
	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 to demonstrates that o and	d on the resident's essment, the facility must nters the facility without an is not catheterized unless the ondition demonstrates that				
	receives appropriate	e treatment and services to t infections and to restore				

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PRINTED: 09/16/2020

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/16/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION G	(X3) DAT CON	E SURVEY IPLETED
		245283	B. WING	€			C 29/2020
NAME OF F	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WAT	ERVIEW PINES LLC				1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 690	Continued From pa continence to the ex §483.25(e)(3) For a incontinence, based comprehensive ass ensure that a reside receives appropriat restore as much no possible. This REQUIREMEN by: Based on observat review, the facility fa incontinence cares residents (R4, R1) r bladder incontinence Findings include: R4's Admission Red R4's diagnoses incl behavioral disturbat weakness. R4's annual Minimu 5/5/20, identified R4 cognition. R4's MD required extensive a	ge 16 xtent possible. I resident with fecal d on the resident's essment, the facility must ent who is incontinent of bowel e treatment and services to rmal bowel function as NT is not met as evidenced ion, interview, and document ailed to ensure timely were provided for 2 of 3 reviewed for bowel and	F		DEFICIENCY)	e, cked to skin iving le. sident t. thers: vities of s per nsure to	
	Catheter Care Area 5/8/20, indicated R4 and her elimination every two hours. R4's Kardex dated incontinent of bladd	Assessment (CAA) dated A had urinary incontinence, needs were to be assessed 7/24/17, indicated R4 was er and had an ostomy. The ff to assess elimination needs,			Date of Compliance: 8/31/2020. Recurrence will be prevented by: Audits of 5 residents will be condu 3x/week x 4, 2x/week x 4, and the weekly x 4 to ensure that their toil needs are completed timely. The will be shared with the facility QAI committee for input on the need to increase, decrease or discontinue	n eting results ข	

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		AND HUMAN SERVICES				FORM	09/16/2020 APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	` '		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED			
		245283	B. WING			C 07/29/2020				
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
THE WAT	TERVIEW PINES LLC				201 8TH STREET SOUTH /IRGINIA, MN 55792					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 690	and check for incor during the day and Kardex further direc ostomy every two h On 7/28/20, at 3:45 room, and she was was facing a nights holding a call light in On 7/28/20, at 3:47 observed to be on. entered R4's room, the door. NA-G exi R4's door was left of seated in a wheelch nightstand near her On 7/28/20, at 4:17 person entered R4's person administere exited the room with unidentified staff per to R4. The staff-per p.m. The resident in wheelchair and face On 7/28/20, at 5:09	 a tinence, every two hours b tinence, every two hours c rounds during the night. The cted staff to check R4's nours. b p.m. R4 was observed in her seated in a wheelchair. R4 tand, near her bed, and was in her left hand. c p.m. R4's call light was c p.m. and she was observed hair, and was facing a c bed. c p.m. an unidentified staff s with medications. The staff d medications to R4 and hin a minute. At 4:19 p.m. the erson again entered R4's room at 4:20 remained seated in a ed a nightstand near her bed. c p.m. R4 was wheeled to the 	F	590	audits. Corrections will be monitored by: DON/ADON/Nurse Managers/Desi	gnee				
	and asked if she wa continued to eat. A chair near R4 and in NA-F stated, "Go al then walked away f again sat near R4 a fluids. At 6:35 p.m.	2 p.m. NA-F approached R4 as finished eating. R4 at 6:22 p.m. NA-F placed a nquired how she was doing. head and finish eating." NA-F rom R4. At 6:24 p.m. NA-F and encouraged her to drink NA-F wheeled R4 from the room. NA-F then exited R4's								

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		AND HUMAN SERVICES				FORM	09/16/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY PLETED
		245283	B. WING				C 29/2020
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WATERVIEW PINES LLC					201 8TH STREET SOUTH /IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	Continued From pa	ge 18	F6	690			
	conducted with NA- usually incontinent, resident much. NA R4 was on a check stated in general, re and changed every had an ostomy, and two hours. NA-F st R4's ostomy was la On 7/28/20, at appr interview was conde R4 required stand b transferred or toilete continent "sometim ostomy and it need hours. NA-G stated checked-and-chang stated she emptied this time, R4's ostom NA-G. R4's ostom NA-G stated it need from ostomy pouch from the ostomy po ostomy pouch was with light brown sto incontinence produc would "normally" ch incontinence produc clean the shower re was waiting to use if room. NA-G stated R4's ostomy pouch	roximately 7:30 p.m. an ucted with NA-G. NA-G stated by assistance when she was ed. NA-G stated R4 was es." NA-G stated R4 had an ed to be emptied every two d R4 also needed to be ged every two hours. NA-G R4's ostomy at 6:30 p.m. At my pouch was observed with y pouch was filled with air and ded to be "burped" (release air). NA-G then released the air ouch. NA-G confirmed R4's approximately one-half full ol. NA-G also confirmed R4's ct was "wet." NA-G stated she hange a resident's ct, however, she needed to bom because another resident it. NA-G then exited R4's I she did not document when					

If continuation sheet Page 19 of 27

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/16/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245283	B. WING				C 29/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE WAT	TERVIEW PINES LLC				I201 8TH STREET SOUTH /IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 690	check-and-change the day, and rounds stated you wound n pouch to be one-ha RN-B stated staff w resident's incontine to be wet. RN-B sta skin breakdown or o infection if an incon changed when soild On 7/29/20, at 3:53 conducted with the The DON stated R4 had an ostomy whic The DON stated sta and change R4 eve stated she would ha shower and care fo incontinence produc Facility policy titled (ADLs), Supporting "Appropriate care a for residents who a independently, with and in accordance R1's Admission Ree R2's diagnoses incl hemiparesis followi (weakness or paral	stated staff were expected to R4 every two hours, during s during night shift. RN-B ot normally expect an ostomy If full of stool in an hour. rould be expected to change a nce product if it was identified ated a resident could have develop a urinary tract tinence product was not	F	690			
		and awareness, abnormal and neuritis (nerve pain), and					

		AND HUMAN SERVICES				FORM	09/16/2020 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DAT COM	E SURVEY IPLETED
		245283	B. WING				C 29/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE WA	TERVIEW PINES LLC				1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 690	contracture of hand tendons, or ligamer movement of the af R1's quarterly MDS had moderately imp decision making, ha behaviors, required for bed mobility, tot extensive assist of was always incontin urinary catheter. R1's quarterly revie 7/27/20, indicated F wore an incontinent for bowel incontinent hours. R1's care plan revie was incontinent of the provide incontinent bowel movement. directives for freque changing. R1's Kardex/care g indicated R1 had a assistance of 2 staf be assessed for elin incontinence every On 7/28/20, from 30 continuous observa checked for incontin p.m. NA-I and NA-E wash up R1 before the wheelchair. Aft	I (fixed tightening of muscle, hts that prevents normal ffected body part). I dated 5/4/20, indicated R1 paired cognitive skills for daily ad no rejection of care extensive assist of two staff al assist of two for transfers, one staff for toileting cares, nent of bowel, and had a I was incontinent of bowel, there and changed every 2 ewed 7/27/20, indicated R1 powel and directed staff to care after each incontinent R1's care plan lacked ency of checking and uide provided 7/28/20, urinary catheter, required ff or perineal care and was to mination needs or checked for	F	590			

If continuation sheet Page 21 of 27

		AND HUMAN SERVICES				FORM	09/16/2020 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245283	B. WING				29/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WAT	ERVIEW PINES LLC				I201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	breakdown on his b	R1 had no indication of skin puttocks.	F€	<u>5</u> 90			
	not been reposition since she started he stated R1 was alrea usually was in bed, up, he would be rep time. Since R1 was repositioned or cha be repositioned and	p.m. NA-E verified R1 had ed or checked and changed er shift at 2:30 p.m. NA-E ady up when she started, and so when she would get him positioned and changed at that s already up, he did not get nged. NA-E stated R1 should d checked or changed every 2 R1 did not get repositioned or on this date.					
		p.m. NA-A stated R1 required h cares, including toileting and					
	be checked and cha at risk for skin brea	p.m. RN-A verified R1 was to anged every 2 hours, and was kdown. RN-A verified R1's check and change every 2					
F 880 SS=D	(DON) stated there communication with got out of bed so st	n shift change as to when R1 aff could reposition and check nely. The DON verified R1 was kdown. n & Control	F 8	380			8/31/20
	infection prevention	Control tablish and maintain an a and control program a safe, sanitary and					

Facility ID: 00582

If continuation sheet Page 22 of 27

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/16/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245283	B. WING	i		C 07/29/2020	
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WAT	ERVIEW PINES LLC				1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	development and tr diseases and infect §483.80(a) Infection program. The facility must es and control program a minimum, the follo §483.80(a)(1) A sys reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based conducted accordin accepted national s §483.80(a)(2) Writte procedures for the p but are not limited to (i) A system of surve possible communic infections before the persons in the facilii (ii) When and to wh communicable dise reported; (iii) Standard and tra to be followed to pre (iv)When and how i resident; including to (A) The type and du depending upon the involved, and (B) A requirement th	ment and to help prevent the ansmission of communicable ions. In prevention and control tablish an infection prevention in (IPCP) that must include, at owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessment og to §483.70(e) and following tandards; en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other ty; iom possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a	F	380			

If continuation sheet Page 23 of 27

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/16/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COMF	E SURVEY PLETED
		245283	B. WING			(07/2	29/2020
NAME OF F	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE WAT	TERVIEW PINES LLC				201 8TH STREET SOUTH IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	circumstances. (v) The circumstance must prohibit emploid disease or infected contact with resider contact with resider contact will transmit (vi)The hand hygier by staff involved in or §483.80(a)(4) A sys- identified under the corrective actions ta §483.80(e) Linens. Personnel must har transport linens so a infection. §483.80(f) Annual r The facility will cond IPCP and update the This REQUIREMEN by: Based on observat review, the facility fa hygiene during perso contamination for 1 during incontinent of Findings include: R1's Admission Rec R2's diagnoses incl hemiparesis following (weakness or parally following a stroke), cognitive functions a posture, neuralgia a	ces under which the facility byees with a communicable skin lesions from direct at the disease; and he procedures to be followed direct resident contact. Atem for recording incidents facility's IPCP and the aken by the facility. Adle, store, process, and as to prevent the spread of eview. Auct an annual review of its eir program, as necessary. NT is not met as evidenced ion, interview, and document ailed to ensure proper hand conal cares to prevent cross of 2 residents (R1) observed	Fδ	380	F880 Infection Prevention & Contro Immediate Corrective Action: NA-E received education on the pro process for sanitizing/washing her h Corrective Action as it applies to oth All residents are at risk to potentially affected. Policies/Procedures/System Change The facility S QAPI committee conc a root cause analysis to identify the problem(s) that resulted in this defic practice, and develop an intervention corrective action plan to prevent recurrence. The Policy and Procedure for Hand Hygiene was reviewed by DON/IP at	per lands. lers: / be es ducted sient n and	

Facility ID: 00582

If continuation sheet Page 24 of 27

						0938-039	
			TIPLE CONSTRUCTION	· · ·	(X3) DATE SURVEY COMPLETED C		
		A. BOILD					
		245283	B. WING		07/	07/29/2020	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	DE		
THE WAT	FERVIEW PINES LLC			1201 8TH STREET SOUTH VIRGINIA, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	Continued From pa	ige 24	F 8	80			
	tendons, or ligamen movement of the a	nts that prevents normal ffected body part).		remains current. Training Education	hand		
	R1's quarterly Minimum Data Set (MDS) dated 5/4/20, indicated R1 had moderately impaired			All NAR⊡s were educated on hand hygiene while completing peri care, b 8/31/2020.			
	cognitive skills for daily decision making, had no rejection of care behaviors, required extensive assist of two staff for bed mobility, total assist of two for transfers, extensive assist of one staff for toileting cares, was always incontinent of bowel,			All staff were educated on ha Hand hygiene education inclutest that measured competer 9/92020 Recurrence will be prevented	uded a post acy by		
	and had a urinary catheter. R1's quarterly review progress notes dated 7/27/20, indicated R1 was incontinent of bowel, wore an incontinent brief, and was to be checked for bowel incontinence and changed every 2			The Director of Nursing, the I Preventionist and other facilit will conduct	nfection		
					udits on all shifts, every day for one veek, then may decrease the frequency ased upon		
	hours. R1's care plan revie	ewed 7/27/20, indicated R1		compliance. Audits should co 100% compliance is met. The Director of Nursing, Infed			
	was incontinent of l provide incontinent	care after each incontinent R1's care plan lacked		Preventionist or designee will results of audits and monitori Quality Assurance Program I	l review the ng with the		
		ency of checking and		(QAPI) program. Corrections will be monitored DON/ADON/Nurse Managers	ored by:		
	indicated R1 had a assistance of 2 stat	uide provided 7/28/20, urinary catheter, required ff for perineal care and was to mination needs or checked for 2 hours.			, 2001g1100		
	and NA-E were sta R1 before transferr wheelchair. NA-E a and donned gloves	p.m. nursing assistant (NA)-I rting to undress and wash up ing R1 to bed from the and NA-I had washed hands . After R1 was transferred to R1's incontinent brief, and					

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		AND HUMAN SERVICES				FORM	09/16/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COM	E SURVEY PLETED
		245283	B. WING	i			C 29/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE WAT	ERVIEW PINES LLC				1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	buttocks. NA-E ther to R1's buttocks and the soiled gloves, a hygiene positioned brief on R1. NA-E a and slightly to the ri canvas from under and placed it on R1 cases on a pillow, a NA-E then put R1's raised R1's head of her hands in R1's b room. NA-E had no after removing her s incontinent cares, a items. On 7/28/20, at 7:07 performed hand hyg following perineal c clean items. NA-E s to sanitize or wash On 7/29/20, at 1:13 stated the expectati done before cares, going from dirty to c should remove glow going from dirty to c On 7/20/20, at 4:00 (DON) stated staff s perform hand hygie clean, before contin The facility policy H directed infection co	's rectal area and lower n opened and applied ointment d rectal area. NA-E removed nd without performing hand and put a clean incontinent and NA-I turned R1 to his back ght to remove the hoyer him. NA-E moved the canvas 's wheelchair. NA-E put pillow and put it under R1's calves. call light within his reach, and the bed. NA-E then washed athroom before exiting the ot performed hand hygiene soiled gloves following and before touching clean p.m. NA-E verified she had giene after removing gloves ares, and before touching stated she was not sure when her hands. p.m. registered nurse (RN)-A ion was for hand hygiene to be after perineal cares, and clean tasks. RN-A stated staff ves and sanitize, and reglove clean tasks.	Fξ	380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER SUPPLIER (LA DENTIFICATION NUMBER: 245283 (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURVEY COMPLETED B WING (X3) DATE SURVEY COMPLETED C NAME OF PROVIDER OR SUPPLER THE WATERVIEW PINES LLC 245283 STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792 STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792 PREEX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOLD BE (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY) OWNER CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 880 Continued From page 26 potentially deadly germs. The policy directed staff to perform hand hygiene before and after assisting a resident with personal cares, toileting, and handling solied or used linens, catheters and urinals, and after removing gloves. F 880			AND HUMAN SERVICES				FORM	09/16/2020 APPROVED 0938-0391
245283 B. WING 07/29/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH THE WATERVIEW PINES LLC 1201 8TH STREET SOUTH VIRGINIA, MN 55792 (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 880 Continued From page 26 potentially deadly germs. The policy directed staff to perform hand hygiene before and after assisting a resident with personal cares, toileting, and handling soiled or used linens, catheters and F 880 F 880	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				СОМ	PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE WATERVIEW PINES LLC 1201 8TH STREET SOUTH VIRGINIA, MN 55792 VIRGINIA, MN 55792 (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 880 Continued From page 26 potentially deadly germs. The policy directed staff to perform hand hygiene before and after assisting a resident with personal cares, toileting, and handling soiled or used linens, catheters and F 880			245283	B. WING	i			
THE WATERVIEW PINES LLC VIRGINIA, MN 55792 (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 880 Continued From page 26 potentially deadly germs. The policy directed staff to perform hand hygiene before and after assisting a resident with personal cares, toileting, and handling soiled or used linens, catheters and F 880	NAME OF F	PROVIDER OR SUPPLIER	L					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 880 Continued From page 26 potentially deadly germs. The policy directed staff to perform hand hygiene before and after assisting a resident with personal cares, toileting, and handling soiled or used linens, catheters and F 880 F 880 F 880 Continued From page 26 potentially deadly germs. The policy directed staff	THE WAT	ERVIEW PINES LLC						
potentially deadly germs. The policy directed staff to perform hand hygiene before and after assisting a resident with personal cares, toileting, and handling soiled or used linens, catheters and	PRÉFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
	F 880	potentially deadly g to perform hand hy assisting a resident and handling soiled	erms. The policy directed staff giene before and after with personal cares, toileting, or used linens, catheters and	F	380			

Facility ID: 00582



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 18, 2020

Administrator The Waterview Pines Llc 1201 8th Street South Virginia, MN 55792

Re: State Nursing Home Licensing Orders Event ID: UHW711

Dear Administrator:

The above facility was surveyed on July 28, 2020 through July 29, 2020 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.

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:

Teresa Ament, Unit Supervisor Email: teresa.ament@state.mn.us Phone: (218) 302-6151 Fax: (218) 723-2359

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

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY PLETED
		00582	B. WING			C 2 9/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO , MN 55792	UTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	survey was comple complaint investiga to be NOT IN comp Requirements for L	n 7/29/20, an abbreviated ted at your facility to conduct tions. Your facility was found liance with 42 CFR Part 483, ong Term Care Facilities.				
Minnosoto D	epartment of Health	laints were found to be				
ABORATOR	Y DIRECTOR'S OR PROVIE	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 08/26/20

Electronically Signed

If continuation sheet 1 of 26

Minneso	ta Department of He	alth			MAPPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED
00582		B. WING	C 7/29/2020		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
	TERVIEW PINES LLC		STREET SC MN 55792	DUTH	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
2 000	Continued From pa	ge 1	2 000		
		H5283025C, H5238026C, 3028C, and H5283029C.			
		ed in ePOC and therefore a uired at the bottom of the first 567 form.			
2 890	MN Rule 4658.0525 Motion	5 Subp. 2 A Rehab - Range of	2 890		8/31/20
	that is directed towa through positioning implemented and m comprehensive resi of nursing services	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which			
	without a limited rar experience reduction	ho enters the nursing home nge of motion does not in in range of motion unless al condition demonstrates range of motion is			
	by:	ent is not met as evidenced			
	review, the facility fa of restorative progra planned programs f	on, interview, and document ailed to ensure implementation ams according to the care for 4 of 4 residents (R1, R2, ed for restorative programs.		F688 Increase/Prevent Decrease in ROM/Mobility Immediate Corrective Action: Resident #1, #2, #4, and #6⊡s restorative programs were reviewed for continued	9
	Findings include:			appropriateness of program. Corrective Action as it applies to others:	
	R1 R1's Admission Red	cord printed 7/30/20, indicated		The Policy and Procedure for Resident Mobility and Range of Motion remains current.	

Minnesota Department of Health STATE FORM

6899

UHW711

If continuation sheet 2 of 26

	NT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	_ETED
		00582	B. WING			, 9/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		I STREET SC A, MN 55792			
(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 ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 890	R1's diagnoses incl hemiparesis followi (weakness or paral following a stroke), cognitive functions posture, neuralgia a contracture of hand tendons, or ligamer movement of the af R1's quarterly Minir assessment dated moderately impaire decision making, ha behaviors, and had 15 minutes over the range of motion wa assessment. R1's Restorative Ne Group POC (plan of indicated R1 was to (PROM) to all joint times weekly, and of was changed to see R1's Restorative Ne Group POC, initiate have heel slides, at internal rotation and right, and left active slides and ankle put A review of R1's res indicated R1 was to left, replace splint a weekly, and monito times weekly right u	uded hemiplegia and ng cerebral infarction ysis on one side of body signs and symptoms involving and awareness, abnormal and neuritis (nerve pain), and (fixed tightening of muscle, nts that prevents normal fected body part). num Data Set (MDS) 5/4/20, indicated R1 had d cognitive skills for daily ad no rejection of care no restorative programs for e assessment period. R1's s not assessed on this ursing Program/Wellness f care), initiated 6/2/14, o have passive range of motior of left upper extremity five on 10/17/14, left hand PROM		All NARs will be re-educat completing restorative exe as ensuring appropriate d the exercises by 8/31/202 The restorative program of will be reviewed monthly be nurse for continued monite participation, and possibilite program. This meeting will in medical record. Date of Compliance: 8/31 Recurrence will be prevent Audits of 5 residents rest programs will be conducte 2x/week x 4, and then we ensure programs are com documented. The results with the facility QAPI com on the need to increase, of discontinue the audits. Corrections will be monito DON/ADON/Nurse Manage	ted on ercises, as well ocumentation of 0. of each resident by a licensed oring of goals, ity of alteration of II be documented 1/2020. hted by: storative ed 3x/week x 4, ekly x 4 to opleted and will be shared mittee for input decrease or	

	NT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	COM	E SURVEY PLETED
		00582	B. WING	·····	07/29/2020	
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SOL MN 55792	JIH		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5) COMPLE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)		DATE
2 890	Continued From pa	age 3	2 890			
	restorative docume following: - From 5/11/20 to 5 completed 2 of 3 o -From 5/18/20 to 5 completed 3 of 3 o - From 5/25/20 to 5 programs were cor extremity programs opportunities. -Documentation fo not provided. -From 6/8/20 to 6/1 completed 3 of 3 o -From 6/15/20 to 6 completed 3 of 3 o -From 6/22/20 to 6 completed 3 of 3 o -From 6/22/20 to 6 completed on uppe opportunities, and were completed 2 -From 6/29/20 to 7 completed on uppe opportunities, and were completed 2 -From 7/6/20, to 7/ extremities were co and for lower extre completed 1 of 3 o - From 7/13/20 to 7 completed 1 of 3 o - From 7/20/20 to 7 completed 2 of 3 o - No refusals were A note written by re assistant (NA)-J in- treatments and did NA-J documented	 /24/20, R1's programs were pportunities. /5/31/20, R1's upper extremity mpleted 4 days and lower is were completed 2 of 3 r week of 6/1/20 to 6/7/20, was 14/20, R1's programs were pportunities. /21/20, R1's programs were pportunities. /28/20, R1's programs were er extremities 3 of 3 for lower extremities, programs were er extremities 3 of 3 for lower extremities, programs were er extremities 3 of 3 for lower extremities, programs were er extremities 3 of 3 for lower extremities, programs were er extremities. 12/20, R1's programs were er extremities. 12/20, R1's programs on upper completed 2 of 3 opportunities. 12/20, R1's programs were pportunities. 12/20, R1's programs on upper completed 2 of 3 opportunities. 12/20, R1's programs were pportunities. 				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			СОМI	E SURVEY PLETED
		00582	B. WING		C 07/29/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	TERVIEW PINES LLC		STREET SOU , MN 55792	JTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 890	Continued From pa	ge 4	2 890			
	there was no restorative aide working that day.					
	R2					
	R2's Admission Record printed 7/29/20, indicated R2's diagnoses included dementia with behavioral disturbance, muscle weakness, and difficulty in walking.					
	had a severe cogni assistance with bec ambulation on the u	dated 4/28/20, indicated R1 tive deficit, required extensive mobility, transfers and unit. R1's MDS further prestorative programs.				
	staff to ambulate R able, with one staff push the wheelchai	ewed 7/22/20, directed nursing 2 two to three times daily as to walk with R2 and one to r behind R2. If R2 refused e re-approached at a later time aily.				
	1/10/11, indicated F following: AROM/P hand exercises thre Restorative Service indicated R2 was to lower extremities th Restorative Service	ervices Plan of Care dated R2 was to have 3 of the ROM, upper extremity and ee times weekly. Another e Plan of Care dated 3/22/11, o have other exercises on tree times weekly. A third es Plan of Care dated R1 was to have specific quad es weekly.				
	indicated R2 was to AROM, and exercis weekly. In addition exercises three tim extremity exercises	storative documentation b have bilateral upper extremity ses as written, three times R2 was to have quad es weekly, and bilateral lower as listed three times a week. cumentation indicated the				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	CONSTRUCTION	СОМ	E SURVEY PLETED C
		00582	B. WING			29/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		I STREET SOL A, MN 55792	JTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 890	Continued From pa	ge 5	2 890			
	completed 1 of 3 op -From 5/18/20 to 5/ completed 0 of 3 op those days, and wa - From 5/25/20 to 5 completed 2 of 3 op the third opportunity -Documentation for not provided. -From 6/8/20 to 6/1 completed 1 of 3 op days after 3-4 appre- From 6/15/20 to 6/ was completed 1 of refused 2 days with one day. -From 6/22/20 to 6/ completed 1 of 3 op two other days. -From 6/29/20 to 7/ completed 1 of 3 op day and "NO" docu -From 7/6/20, to 7/1 documented refuse blank a third day. F dated 7/6/20 and 7/ R2's refusals on the - From 7/13/20 to 7 documentation was third day. 7/15 - From 7/20/20 to 7 completed 2 of 3 op through a third day. In addition, R2 had completed and doc indicated R2 was to	 24/20, R2's programs were opportunities, R2 refused 2 of lked instead on the third day. /31/20, R2's ROM was opportunities, and R2 refused y. week of 6/1/20 to 6/7/20, was opportunities and R2 refused 2 oaches each day. 21/20, R2's ROM was opportunities, and R2 refused 2 oaches each day. 21/20, R2's ROM programs f 3 opportunities, and R2 refused 2 or re-approaches documented 28/20, R2's ROM was opportunities, and R2 refused 5/20, R2's ROM was opportunities, and R2 refused 5/20, R2's ROM was opportunities, with a refusal one mented the third day. 12/20, R2's programs were ed on 2 of 3 opportunities and R2's Restorative Aide Notes (11/20, provided explanation of ose dates. /19/20, R2's ROM was opportunities and zeros a /26/20, R2's ROM was opportunities and a line drawn 				

Minneso	ta Department of He	alth				APPROVE
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	or contraction		A. BUILDING:			
		00582	B. WING		– C - 07/29/202	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	TERVIEW PINES LLC	1201 8TH	STREET SOU	JTH		
	IERVIEW PINES LLC	VIRGINIA	, MN 55792			
(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) COMPLETE DATE
2 890	Continued From pa	ge 6	2 890			
	assist of 2.					
	Response History r indicated R2's amb ambulation is also r of both documents revealed R2 either	n on the Plan of Care eport for the month of July, ulation is recorded. R2's recorded in Tasks. A review for the month of July/2020, ambulated or was offered used less than 3 times daily 5				
		p.m. two different staff were mbulation with R2, who				
		p.m. R2 was observed to with two staff assist according				
	restorative aide who	a.m. NA-B stated the o did restorative programs and nts did not do restorative				
	-	a.m. NA-A stated the prestorative programs and the n.				
	stated R1 did not a left leg, and she rep stated R1 does RO right leg fine, and is	4 a.m. restorative aide/NA-C llow them to do ROM of the ported that to nursing. NA-C M programs on hands and a usually compliant. NA-C refuse, they document on				
	(DON) stated the re to work on the unit,	2 a.m. the director of nursing estorative aide is never pulled but sometimes they do not aide. The DON stated they had				

	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED
		00582	B. WING			29/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SOU MN 55792	JTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 890	been in transition w DON stated if a res restorative program another day. On 7/29/20, at 1:13 stated the nursing a ambulation if the re- working that day. F passive ROM. RN- ROM of his left lowe ulcers. RN-A verifie for the nursing assis he probably had nor restorative aides we would have a poten On 7/29/20, at 2:50 have restorative me them. The DON sta status and any char stiffness or a declin orders. The DON sta status. On 7/29/20, at 3:22 when a resident has because it pops up they document "not On 7/29/20, at 4:08 have tried different restorative and for F documentation tool so many different w makes it more diffic	ith new restorative aides. The ident misses a day of is, it should be made up p.m. registered nurse (RN)-A assistants would do ROM, or storative aides were not RN-A stated they would do the A verified R1 was not allowing er extremity due to pressure d R1 did not have a signs off stants to do ROM, so stated t gotten ROM when the ere not there, and therefore tial for a decline in ROM. p.m. the DON stated they bettings, but do not document ted they discussed residents' nges, such as increased e, and then would get therapy tated there were no notes on dicate there was a change in p.m. NA-K stated they know is a restorative program on the computer. NA-K stated applicable" if it was not done. p.m. the DON stated they ways of documenting R2, the family has a for ambulation, also. Having rays and places to document sult for staff and difficult to ted restorative programs	2 890			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED
		00582	B. WING		07/	29/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		I STREET SOL A, MN 55792	JTH		
(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
2 890	Continued From pa	ge 8	2 890			
	R4					
	R4's diagnoses incl	cord dated 7/29/20, indicated luded dementia without nce and muscle weakness.				
	severely impaired of identified R4 did no	ated 5/5/20, identified R4' had cognition. The MDS further t walk, and had not rejected of en day look-back period				
	unable to ambulate	ed 8/12/19 indicated R4 was safely due to osteoarthritis ess. The care plan directed e (walk).				
	Restorative Service	munication to Wellness / es document dated 12/21/26, ambulation was to be				
	indicated R4 was to weekly. The restor indicated	torative documentation be ambulated six times ative documentation further				
	of six opportunities - From 5/25/20 to 5 four of six opportun	/31/20, R4 was ambulated ities.				
	of six opportunities	/26/20, R4 was ambulated five				
	- No refusais were	uocamentea.				
	R6's Admission Re	cord dated 7/29/20, indicated luded osteoporosis and				

	ota Department of He	(X1) Provider/Supplier/Clia	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
		00582	B. WING		C 07/29/2020	
					077	29/2020
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
THE WA	TERVIEW PINES LLC		1 STREET SOU A, MN 55792	JIH		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
2 890	Continued From pa	ge 9	2 890			
	R6's annual MDS dated 6/26/20, identified R6's BIMS score was 14 which indicated intact cognition. R6's MDS further identified she had not rejected care.					
	6/24/19, indicated F stretches to her har	ervices Plan of Care dated R6 was to be provided gentle mstrings and ankles related to stretches were to be nes weekly.				
	indicated R6 was to her lower extremitie restorative docume - From 5/11/20 to 5 performed one of th - From 5/25/20 to 5 performed two of th - From 6/29/20 to 7 performed one of th	/31/20, R6's stretching was nee opportunities. /5/20, R6's stretching was nee opportunities. /19/20, R6's stretching was				
	documentation was assistant (NA)-C. N documentation exis refused ambulation didn't get walked." restorative aides re believed no one per	5 a.m., R4's restorative reviewed with nursing NA-C confirmed no sted which indicated R4 and stated "she probably NA-C stated there were two cently hired. NA-C stated she rformed restorative cares des were not scheduled.				
	conducted with the nursing staff walked	8 p.m. an interview was DON. The DON stated d residents when restorative eduled. The DON stated lists				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		СОМ	E SURVEY PLETED C
		00582 B.		B. WING		29/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		I STREET SOU A, MN 55792	тн		
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 890	were placed at each which residents need stated NAs' were not stretching as they were scheduled daily, how which no one was st DON stated staff do progress notes. The note existed it was a care. On 7/29/20, at 12:20 conducted with RN- performed restorative aides were not avait staff performed gen residents. RN-B state when residents were On 7/29/20, at 1:07 conducted with the restorative aides resistanted. On 7/29/20, at 3:08 conducted with NA- was at the nurses' started. On 7/29/20, at 3:08 conducted with NA- was revise confirmed the resto R4 needed to be wate On 7/29/20, at 3:08 conducted with NA- manager placed a literative of the started of the started of the startes o	 A nurses' station so staff knew eded to get walked. The DON of allowed to perform vere not trained by therapy. Storative aides were wever, there may be a day in scheduled due to training. The ocumented refusals on therapy e DON stated if no progress likely a resident did not refuse 6 p.m. an interview was B. RN-B stated nursing staff ve cares when restorative lable. RN-B stated nursing staff documented e walked, but not stretched. p.m. an interview was DON. The DON stated two signed when COVID-19 p.m. an interview was F. NA-F stated a document station which indicated what eeded to be completed. The ewed, with NA-F and NA-F rative sheet lacked indication 				

CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED C	
	00582	B. WING		07/29/2020	
OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
PINES LLC			ТН		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
ware when ted. NA-H s was getting tive aides' d orative offic 0/20, at 3:32 ted with the restorative p ress. The D ht of the pro- f. 0/20, at 3:53 ted with the spected to for ent plans. T he record to cluded. The id R6 refuse rd their nam policy Resid dated 7/17, range of mo- s to increase se in ROM." ents with lim- iate service tain or impro- lity is unavo SSTED MET ector of nurs o and impler to the facilit	restorative cares were not stated staff assumed R4's g done. NA-H stated the ocumentation was locked in e afterhours. P.m. an interview was DON. The DON stated the orogram was a work ON stated she recently started ogram and there wasn't a good p.m. an interview was DON. The DON stated staff ollow resident restorative he DON stated she needed to o see what R6's restorative DON stated she did not know ed restorative cares, but had hes a lot. dent Mobility and Range of directed, "Residents with tion will receive treatment and e and/or prevent a further The policy further directed, ited mobility will receive is, equipment and assistance ove mobility unless reduction idable."		DEFICIEN	57)	
	OR SUPPLIER I PINES LLC SUMMARY STA CH DEFICIENCY ULATORY OR L ULATORY OR L Ided From para ware when ted. NA-H s was getting tive aides' d torative offic 2/20, at 3:32 ted with the restorative p ress. The D ht of the pro- ff. 2/20, at 3:53 ted with the restorative p ress. The D ht of the pro- ff. 2/20, at 3:53 ted with the restorative p ress. The D ht of the pro- ff. 2/20, at 3:53 ted with the restorative p ress. The D ht of the pro- ff. 2/20, at 3:53 ted with the restorative p ress. The D ht of the pro- ff. 2/20, at 3:53 ted with the restorative p ress. The D ht of the pro- ff. 2/20, at 3:53 ted with the restorative p ress. The D ht of the pro- ff. 2/20, at 3:53 ted with the restorative p ress. The D STED MET o and impler to the facility or designee, staff related	CIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00582 00582 OR SUPPLIER STREET AI 1201 8TH VIRGINI/ VPINES LLC 1201 8TH VIRGINI/ SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION) Image 11 Invare when restorative cares were not ted. NA-H stated staff assumed R4's y was getting done. NA-H stated the tive aides' documentation was locked in torative office afterhours. 0/20, at 3:32 p.m. an interview was ted with the DON. The DON stated the restorative program was a work ress. The DON stated she recently started ht of the program and there wasn't a good ff. 0/20, at 3:53 p.m. an interview was ted with the DON. The DON stated staff expected to follow resident restorative ent plans. The DON stated she needed to he record to see what R6's restorative ent plans. The DON stated she needed to he record to see what R6's restorative cluded. The DON stated she did not know and R6 refused restorative cares, but had ard their names a lot. policy Resident Mobility and Range of dated 7/17, directed, "Residents with	CLENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE DOTSUPPLIER 00582 B. WING OR SUPPLIER STREET ADDRESS, CITY, ST IDENTIFICATION NUMBER: 1201 8TH STREET SOUVIRGINIA, MN 55792 SUMMARY STATEMENT OF DEFICIENCIES ID COR DEFICIENCIES ID SUMMARY STATEMENT OF DEFICIENCIES ID CH DEFICIENCY MUST BE PRECEDED BY FULL ID ULATORY OR LSC IDENTIFYING INFORMATION) PREFIX Ided From page 11 2 890 ware when restorative cares were not ted. ted. NA-H stated staff assumed R4's was getting done. NA-H stated the was getting done. NA-H stated the tive aides' documentation was locked in torative office afterhours. 9/20, at 3:32 p.m. an interview was ted with the DON. The DON stated staff ted with the DON. The DON stated staff topoff. 2/20, at 3:53 p.m. an interview was ted with the DON. The DON stated staff ted with the DON. The DON stated staff topoff ated 7/17, directed, "Residents with range of motion will receive treatment and s to increase and/or prevent a further se in ROM." The policy further directed, inst with limited mobility will receive<	CIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION ORSUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE IDENTIFICATION NUMBER: 1201 8TH STREET SOUTH VIRGINIA, MN 55792 PROVIDER'S PLAN OF SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CH DEFICIENCY MUST BE PRECEDED BY FULL PRETIX ULATORY OR LSC IDENTIFYING INFORMATION) PRETIX Ied From page 11 2 890 ware when restorative cares were not ted. NA-H stated staff assumed R4's was getting done. NA-H stated the testorative office afterhours. 3/20, at 3:32 p.m. an interview was ted with the DON. The DON stated the restorative program was a work ress. The DON stated she recently started nt of the program and there wasn't a good ff. Stated she ineeded to per relians. The DON stated she needed to he record to see what R6's restorative policy Resident Mobility and Range of dated 7/17, directed, "Residents with range of motion will receive treatment and sto increase and/or prevent a further se in ROM." The policy further directed, reseive that the assistance tatin or improve mobility unless reduction </td <td>ECTION IDENTIFICATION NUMBER: A. BUILDING: </td>	ECTION IDENTIFICATION NUMBER: A. BUILDING:

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY	
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		00582	B. WING		07/29/2020	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HE WA	TERVIEW PINES LLC		STREET SC MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE	
2 890	Continued From pa	age 12	2 890			
	audits to ensure co	ompliance.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900		8/31/20	
	comprehensive res of nursing services	sores. Based on the sident assessment, the director must coordinate the nursing care plan which				
	without pressure s pressure sores unl condition demonstr	to enters the nursing home ores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and				
	receives necessar	who has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by:	ent is not met as evidenced				
	review, the facility f and off-loading of p	ion, interview, and document failed to ensure repositioning pressure according to the care relopment of pressure ulcers (R1) reviewed for		F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer Immediate Corrective Action: Resident #1 s care plan, group sheet, and Kardex was updated with individualized repositioning needs.		
	Findings include:			Corrective Action as it applies to others The Policy and Procedure for Skin Assessment and Wound Management		
		cord printed 7/30/20, indicated luded hemiplegia and		remains current. All licensed nurses and NARs will be		

If continuation sheet 13 of 26

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		00582	B. WING		C 07/29/2020	
	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	FERVIEW PINES LLC		STREET SO MN 55792			
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLET DATE
2 900	Continued From pa	age 13	2 900			
	hemiparesis followi (weakness or paral following a stroke), cognitive functions posture, neuralgia a contracture of hand tendons, or ligamen movement of the a R1's quarterly Minin 5/4/20, indicated R cognitive skills for or rejection of care be assist of two staff for two staff for transfe staff for toileting ca incontinent of bowe R1 had no pressure reducing device in or R1's quarterly revie 7/27/20, indicated a (tool to assist in der breakdown) had be determination was skin breakdown. R indicated R1 had th (partial thickness lo dermis presenting a red pink wound be present as an intac blister) to the outsid from resting on the interventions had b notes additionally in and repositioned ev bowel incontinence	ing cerebral infarction lysis on one side of body signs and symptoms involving and awareness, abnormal and neuritis (nerve pain), and d (fixed tightening of muscle, nts that prevents normal ffected body part). mum Data Set (MDS) dated 1 had moderately impaired daily decision making, had no ehaviors, required extensive or bed mobility, total assist of ers, extensive assist of one res, and was always el. R1's MDS further indicated e ulcers, and had a pressure chair and bed. ew progress notes dated a Braden Scale assessment termining risk of skin een completed, and made that R1 was at risk for 1's progress notes further nree Stage 2 pressure injuries		re-educated on the need to sheets/Kardex for individua repositioning programs by & All residents will be reviewed that their repositioning need on the CNA group sheets u independent. Care plans ar were updated as well. Date of Compliance: 8/31/2 Recurrence will be prevente Audits of 5 residents repo will be conducted 3x/week x 4, and then weekly x 4 to as practice is still appropriate. will be shared with the facili committee for input on the n increase, decrease or disco audits. Corrections will be monitore DON/ADON/Nurse Manage	lized 3/31/2020. Id to ensure ds are indicated nless they are nd Kardex □s 2020. Ed by: sitioning plans x 4, 2x/week x ssure this The results ty QAPI need to ontinue the ed by:	
		breakdown related to impaired				

ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/29/2020		
				1 077	//29/2020	
AME OF PROVIDER OR SUPPLIER	1201 8TH	DRESS, CITY, ST STREET SOU , MN 55792				
REFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
current pressure inj R1's care plan furth incontinent of bowe assistance of with p lacked directives for repositioning, and of breakdown. R1's Kardex/care g indicated R1 require bed mobility and tra- elimination needs a group sheets lacked and off-loading R1. On 7/28/20, from 3: continuous observa- off-loaded or signifu- seated in his wheel- any time was appro 6:43 p.m. nursing a starting to undress transferring R1 to b R1 was transferred movement from R1 R1 had no indicatio buttocks. On 7/28/20, at 7:03 to be repositioned er resident asks more repositioning inform sheets. NA-I stated toilets everyone wh dinner, and after dir	 incontinence and had a jury to left outer foot and ankle. her indicated R1 was l and directed staff to provide berineal cares. R1's care plan r frequency of turning and off-loading to prevent skin uide provided 7/28/20, ed assistance of two staff for ansfers, and was to have assessed every 2 hours. R1's d directives for repositioning 55 p.m. to 6:43 pm. during ations, R1 had not been cantly repositioned while chair. Change in position at eximately 15-20 degrees. At ssistant (NA)-I and NA-E were and wash up R1 before and w	2 900				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
			A. BUILDING:		C 07/29/2020	
		00582	B. WING			
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	TERVIEW PINES LLC		I STREET SOL A, MN 55792	JTH		
(X4) ID SUMMARY STATE		TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ge 15	2 900			
	usually was in bed, up, he was reposition was already up, he off-loaded. NA-E similar repositioned every 2 not get repositioned On 7/29/20, at 9:55 total assistance with repositioning. On 7/29/20, at 1:13 verified R1 was to be and was at risk for similar repositioned timely. lacked direction for pretty much everyo On 7/20/20, at 4:00 (DON) stated there communication with got out of bed so st The DON verified Fibreakdown. The DO repositioned in his of pressure, and did a was not complete of The facility policy Similar Management dated and care lists be up and care provided a physician orders.	2 hours, and verified R1 did d in 2 hours on this date. p.m. NA-A stated R1 required h cares, including toileting and p.m. registered nurse (RN)-A be repositioned every 2 hours, skin breakdown when not . RN-A verified R1's Kardex repositioning R1, but said ne is every 2 hours.				
	all residents at risk they are receiving the	for pressure ulcers to assure				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY DMPLETED
		00582	B. WING 07		
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S		
THE WAT	TERVIEW PINES LLC		H STREET SO A, MN 55792	UTH	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
2 900	Continued From pa	age 16	2 900		
	pressure ulcers. T designee, could co delivery of care; to services are impler pressure ulcer deve	nd to promote healing of he director of nursing, or nduct random audits of the ensure appropriate care and nented; to reduce the risk for elopment. R CORRECTION: Twenty-one			
2 910	MN Rule 4658.052 Incontinence	5 Subp. 5 A.B Rehab -	2 910		8/31/20
	have a continuous management to rec unnecessary use o comprehensive res home must ensure A. a resident w without an indwellir unless the resident that catheterization B. a resident w receives appropriat prevent urinary trac	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 ng catheter is not catheterized 's clinical condition indicates was necessary; and ho is incontinent of bladder te treatment and services to ct infections and to restore as ler function as possible.			
	by: Based on observat review, the facility f incontinence cares	ent is not met as evidenced ion, interview, and document ailed to ensure timely were provided for 2 of 3 reviewed for bowel and ce.		F690 Bowel/Bladder Incontinence, Catheter, UTI Immediate Corrective Action: Resident #1 and #4 skin was checked to ensure that they did not have any skin breakdown as a result of not receiving)

If continuation sheet 17 of 26

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	ETED
		00582	B. WING			, 9/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	TERVIEW PINES LLC		I STREET SC A, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 910	Continued From pa	ge 17	2 910			
2 910	Findings include: R4's Admission Rec R4's diagnoses incl behavioral disturban weakness. R4's annual Minimu 5/5/20, identified R4 cognition. R4's MD required extensive a ostomy, and was all R4's Urinary Inconti Catheter Care Area 5/8/20, indicated R4 and her elimination every two hours. R4's Kardex dated T incontinent of bladd Kardex directed sta and check for incond during the day and 1 Kardex further direct ostomy every two h On 7/28/20, at 3:45 room, and she was was facing a nights' holding a call light in On 7/28/20, at 3:47 observed to be on. entered R4's room, the door. NA-G exi	cord dated 7/29/20, indicated uded dementia without nce, heart failure and muscle im Data Set (MDS) dated i had severely impaired S further identified she assistance toileting, had an ways incontinent of bladder. nence and Indwelling Assessment (CAA) dated i had urinary incontinence, needs were to be assessed 7/24/17, indicated R4 was er and had an ostomy. The ff to assess elimination needs, tinence, every two hours rounds during the night. The cted staff to check R4's ours. p.m. R4 was observed in her seated in a wheelchair. R4 tand, near her bed, and was		incontinent cares per their s NAR-E, NAR-G, and NAR-I educated on need to complet toileting cares per NAR care Corrective Action as it applie The Policy and Procedure for Daily Living remains current All NARs will be re-educated completing resident toileting NAR care sheet by 8/31/202 All residents will be reviewed that their toileting needs are care sheets. Date of Compliance: 8/31/2 Recurrence will be prevente Audits of 5 residents will be 3x/week x 4, 2x/week x 4, a x 4 to ensure that their toilet completed timely. The resu shared with the facility QAP input on the need to increas discontinue the audits. Corrections will be monitore DON/ADON/Nurse Manage	were ete resident e sheet. es to others: or Activities of d on cares per 20. d to ensure to on the NAR 2020. d by: conducted nd then weekly ing needs are lts will be I committee for e, decrease or d by:	

	a Department of He OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED C
		00582	B. WING			29/2020
NAME OF PR	OVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE		
THE WATE	RVIEW PINES LLC		STREET SOU MN 55792	ІТН		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
<pre>() F F F F F F F F F F F F F F F F F F F</pre>	berson entered R4's berson administered exited the room with unidentified staff per oom. The staff per o R4. The staff-per o R4 and changed every the continent much. NA-F stafed in general, re and changed every the continent sometime continent "sometime continent "sometime	p.m. an unidentified staff s with medications. The staff d medications to R4 and hin a minute. At 4:19 p.m. the rson again entered R4's rson administered eye drops son exited R4's room at 4:20 remained seated in a ed a nightstand near her bed. p.m. R4 was wheeled to the 2 p.m. NA-F approached R4 as finished eating. R4 t 6:22 p.m. NA-F placed a nquired how she was doing. head and finish eating." NA-F rom R4. At 6:24 p.m. NA-F and encouraged her to drink NA-F wheeled R4 from the room. NA-F then exited R4's p.m. an interview was F. NA-F stated R4 was not but she didn't work with the -F stated she was unsure if and change schedule. NA-F esidents were to be checked two hours. NA-F stated R4 I staff were to check it every ated she was unsure when	2 910			

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			Сом	E SURVEY PLETED C
00582	B. WING			29/2020
STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
		тн		
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
ged every two hours. NA-G ged every two hours. NA-G d R4's ostomy at 6:30 p.m. At omy pouch was observed with y pouch was filled with air and ded to be "burped" (release air n). NA-G then released the air buch. NA-G confirmed R4's approximately one-half full bol. NA-G also confirmed R4's act was "wet." NA-G stated she hange a resident's act, however, she needed to oom because another resident it. NA-G then exited R4's d she did not document when n was last emptied. 26 p.m. an interview was jistered nurse (RN)-B. RN-B mally incontinent and also had stated staff were expected to R4 every two hours, during s during night shift. RN-B not normally expect an ostomy alf full of stool in an hour. vould be expected to change a ence product if it was identified tated a resident could have develop a urinary tract ntinence product was not ed. 8 p.m. an interview was o director of nursing (DON). 4 was incontinent of urine, and ich she didn't empty herself. aff were supposed to check ery two hours. The DON				
	IDENTIFICATION NUMBER: 00582 STREET AI 1201 8TH VIRGINIZ ATEMENT OF DEFICIENCIES 'Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) age 19 ged every two hours. NA-G d R4's ostomy at 6:30 p.m. At omy pouch was observed with ay pouch was filled with air and ded to be "burped" (release air n). NA-G then released the air pouch. NA-G confirmed R4's a approximately one-half full pool. NA-G also confirmed R4's a approximately one-half full pool. NA-G then exited R4's a back did not document when hange a resident's uct, however, she needed to poom because another resident it. NA-G then exited R4's d she did not document when n was last emptied. 26 p.m. an interview was gistered nurse (RN)-B. RN-B mally incontinent and also had stated staff were expected to e R4 every two hours, during is during night shift. RN-B not normally expect an ostomy alf ful	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING: 00582 B. WING STREET ADDRESS, CITY, ST 1201 8TH STREET SOU VIRGINIA, MN 55792 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ID PREFIX TAG ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) age 19 2 910 Ged every two hours. NA-G that's ostomy at 6:30 p.m. At omy pouch was observed with ity pouch was filled with air and ded to be "burped" (release air n). NA-G then released the air opuch. NA-G confirmed R4's is approximately one-half full pool. NA-G also confirmed R4's is tot was "wet." NA-G stated she hange a resident's uct, however, she needed to oom because another resident it. NA-G then exited R4's d she did not document when n was last emptied. 26 p.m. an interview was gistered nurse (RN)-B. RN-B mally incontinent and also had stated staff were expected to rR 4 every two hours, during Is during night shift. RN-B not normally expect an ostomy alf full of stool in an hour. would be expected to change a ence product if it was identified tated a resident could have develop a urinary tract ntinence product was not led. 3 p.m. an interview was e director of nursing (DON). 4 was incontinent of urine, and ich she didn't empty herself. Laff were supposed to check ery two hours. The DON	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: 00582 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 12018TH STREET SOUTH VIRGINIA, MN 55792 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCI DENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF (EACH CORRECTIVE CORSS-REFERENCED TO DEFICIENCIES age 19 2 910 ged every two hours. NA-G I R4's ostomy at 6:30 p.m. At my pouch was observed with my pouch was observed with pup pouch was observed with pup ouch mas observed with pup ouch was alset engled. 26 p.m. an interview was pistered nurse (RN)-B. RN-B mally incontinent and also had stated staff were expected to rR4 every two hours, during Is during night shift. RN-B not normally expect an ostomy all full of stool in an hour. would be expected to change a ence product if it was identified tated a resident could have develop a urinary tract ntinence product was not led. 3 p.m. an interview was edirector of nursing (DON). 4 was incontinent of urine, and ich she didn't empty herself. aff were supposed to checkck ery two hours. The DON <td>(X1) PROVIDER/SUPPLEXCLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING:</td>	(X1) PROVIDER/SUPPLEXCLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING:

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	СОМ	E SURVEY PLETED
		00582	B. WING		07/	29/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		I STREET SOU A, MN 55792	JTH		
(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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	ige 20	2 910			
	incontinence product was identified to be wet.					
	(ADLs), Supporting "Appropriate care a for residents who a independently, with and in accordance R1's Admission Re R2's diagnoses incl hemiparesis followi (weakness or paral following a stroke),	Activities of Daily Living dated 3/18, directed, and services will be provided re unable to carry out ADLs the consent of the resident with the plan of care" cord printed 7/30/20, indicated luded hemiplegia and ng cerebral infarction ysis on one side of body signs and symptoms involving				
	posture, neuralgia a contracture of hance	and awareness, abnormal and neuritis (nerve pain), and I (fixed tightening of muscle, nts that prevents normal ffected body part).				
	had moderately imp decision making, ha behaviors, required for bed mobility, tot extensive assist of	dated 5/4/20, indicated R1 baired cognitive skills for daily ad no rejection of care extensive assist of two staff al assist of two for transfers, one staff for toileting cares, hent of bowel, and had a				
	7/27/20, indicated F wore an incontinent	ew progress notes dated R1 was incontinent of bowel, t brief and was to be checked nce and changed every 2				
	was incontinent of l provide incontinent bowel movement.	ewed 7/27/20, indicated R1 bowel and directed staff to care after each incontinent R1's care plan lacked ency of checking and				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		DENTIFICATION NONDER.	A. BUILDING:			
		00582	B. WING			C 29/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
	FERVIEW PINES LLC		I STREET SOL A, MN 55792	JTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 21	2 910			
	changing.					
	indicated R1 had a assistance of 2 staf be assessed for elin incontinence every On 7/28/20, from 3: continuous observa checked for incontin p.m. NA-I and NA-E wash up R1 before the wheelchair. Aft NA-E washed bowe	55 p.m. to 6:43 pm. during tions, R1 had not been hence or changed. At 6:43 were starting to undress and transferring R1 to bed from er R1 was transferred to bed, el movement from R1's rectal R1 had no indication of skin				
	not been reposition since she started he stated R1 was alrea usually was in bed, up, he would be rep time. Since R1 was repositioned or cha be repositioned and	p.m. NA-E verified R1 had ed or checked and changed er shift at 2:30 p.m. NA-E ady up when she started, and so when she would get him positioned and changed at that is already up, he did not get nged. NA-E stated R1 should d checked or changed every 2 R1 did not get repositioned or on this date.				
		p.m. NA-A stated R1 required n cares, including toileting and				
	be checked and characterisk for skin brea	p.m. RN-A verified R1 was to anged every 2 hours, and was kdown. RN-A verified R1's check and change every 2				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		E SURVEY MPLETED
		00582	B. WING	07	/29/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
THE WA	TERVIEW PINES LLC		STREET SC , MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 910	On 7/20/20, at 4:00 (DON) stated there communication with got out of bed so st for incontinence tim at risk for skin brea SUGGESTED MET The director of nurs review and revise p to ensuring appropt to incontinence. Th designee, could de staff and develop a staff are providing t	p.m. the director of nursing should have been in shift change as to when R1 aff could reposition and check hely. The DON verified R1 was kdown. THOD OF CORRECTION: sing (DON), or designee, could policies and procedures related riate care and services related riate care and services related ne director of nursing, or velop a system to educate monitoring system to ensure	2 910		
21375	Program Subpart 1. Infection home must establis	D Subp. 1 Infection Control; on control program. A nursing sh and maintain an infection signed to provide a safe and nt.	21375		8/31/20
	by: Based on observative review, the facility for hygiene during person contamination for 1 during incontinent of Findings include:	ent is not met as evidenced ion, interview, and document ailed to ensure proper hand sonal cares to prevent cross of 2 residents (R1) observed cares.		F880 Infection Prevention & Control Immediate Corrective Action: NA-E received education on the proper process for sanitizing/washing her hands while performing peri care. Corrective Action as it applies to others: The Policy and Procedure for Hand Hygiene remains current. All NARs were re-educated on hand	

Minnesota Department of Health STATE FORM

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UHW711

If continuation sheet 23 of 26

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE COMPI	LETED	
		00582	B. WING		07/2	29/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE			
THE WA	TERVIEW PINES LLC		I STREET SO A, MN 55792				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21375	Continued From pa	ge 23	21375				
	R2's diagnoses incl hemiparesis followi (weakness or paral following a stroke), cognitive functions posture, neuralgia a contracture of hand tendons, or ligamer movement of the at R1's quarterly Minir 5/4/20, indicated R cognitive skills for or rejection of care be assist of two staff for two for transfers, ex toileting cares, was and had a urinary of R1's quarterly revie 7/27/20, indicated F wore an incontinent for bowel incontinent hours. R1's care plan revie was incontinent of B provide incontinent bowel movement. directives for freque changing. R1's Kardex/care g indicated R1 had a	luded hemiplegia and ng cerebral infarction ysis on one side of body signs and symptoms involving and awareness, abnormal and neuritis (nerve pain), and I (fixed tightening of muscle, nts that prevents normal ffected body part). num Data Set (MDS) dated 1 had moderately impaired laily decision making, had no haviors, required extensive or bed mobility, total assist of xtensive assist of one staff for always incontinent of bowel,		hygiene, including hand h performing peri care. All N educated on peri care and verbally, and via a video of All other staff will be educ hygiene by 9/1/2020. Date of Compliance: 8/3 Recurrence will be prever In order to ensure the def does not happen again, th designee, will conduct ha audits, including NARS, p handwashing while perfor on staff member from all for one week, weekly for a monthly for 2 months, the review. Corrections will be monito DON/ADON/Nurse Manager	VARs were d handwashing on peri care. cated on hand 1/2020. nted by: ficient practice ne DON or nd hygiene performing rming peri care, shifts, every day, 8 weeks, and en bring to QA to pred by:		
	be assessed for eli incontinence every On 7/28/20, at 6:43	mination needs or checked for					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C
		00582	B. WING			29/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		I STREET SOL A, MN 55792	JTH		
(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
21375	Continued From pa	age 24	21375			
	and donned gloves bed, NA-I lowered NA-E washed and R1 was turned to the movement from R1 buttocks. NA-E the to R1's buttocks and the soiled gloves, a hygiene positioned brief on R1. NA-E a and slightly to the r canvas from under and placed it on R1 cases on a pillow, a NA-E then put R1's raised R1's head o her hands in R1's to room. NA-E had n after removing her incontinent cares, a items.	and NA-I had washed hands After R1 was transferred to R1's incontinent brief, and rinsed R1's perineal area, and he left. NA-E washed bowel I's rectal area and lower n opened and applied ointmen do rectal area. NA-E removed and without performing hand and put a clean incontinent and NA-I turned R1 to his back ight to remove the hoyer him. NA-E moved the canvas I's wheelchair. NA-E put pillow and put it under R1's calves. a call light within his reach, and f the bed. NA-E then washed bothroom before exiting the ot performed hand hygiene soiled gloves following and before touching clean				
	performed hand hy following perineal c	' p.m. NA-E verified she had giene after removing gloves ares, and before touching stated she was not sure when her hands.				
	stated the expectat done before cares, going from dirty to	p.m. registered nurse (RN)-A tion was for hand hygiene to be after perineal cares, and clean tasks. RN-A stated staff ves and sanitize, and reglove clean tasks.				
	(DON) stated staff) p.m. the director of nursing should change gloves, and ene when going from soiled to				

		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
		00582	B. WING		C 07/29/2020	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	FERVIEW PINES LLC		H STREET SOL A, MN 55792	ІТН		
(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 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21375	Continued From pa	age 25	21375			
	clean, before conti	nuing another task.				
	directed infection c hygiene and would potentially deadly g to perform hand hy assisting a residen	land Hygiene dated 6/17, ontrol begins with hand reduce the spread of lerms. The policy directed staff giene before and after t with personal cares, toileting, d or used linens, catheters and emoving gloves.				
	The director of nurs review and revise p on appropriate indi- assure an infection established, mainta	ained and monitored to assure residents in a safe manner				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				