DEPARTMENT OF HEALTH

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	C 07/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 000	INITIAL COMMENTS On 7/28/20 and 7/29/29, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5283025C, H5238026C, H5283027C, H5283028C, and H5283029C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		8/31/20

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

Electronically Signed | 08/26/2020

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F 686	Continued From page 1 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure repositioning and off-loading of pressure according to the care plan to prevent development of pressure ulcers for 1 of 3 residents (R1) reviewed for repositioning. Findings include: R1's Admission Record printed 7/30/20, indicated R1's diagnoses included hemiplegia and hemiparesis following cerebral infarction (weakness or paralysis on one side of body following a stroke), signs and symptoms involving cognitive functions and awareness, abnormal posture, neuralgia and neuritis (nerve pain), and contracture of hand (fixed tightening of muscle, tendons, or ligaments that prevents normal movement of the affected body part). R1's quarterly Minimum Data Set (MDS) dated 5/4/20, indicated R1 had moderately impaired 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 staff for transfers, extensive assist of one staff for toileting cares, and was always incontinent of bowel. R1's MDS further indicated R1 had no pressure ulcers, and had a pressure reducing device in chair and bed. R1's quarterly review progress notes dated 7/27/20, indicated a Braden Scale assessment (tool to assist in determining risk of skin	F 686	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. Corrective Action as it applies to others: The Policy and Procedure for Skin Assessment and Wound Management remains current. All licensed nurses and NARs will be re-educated on the need to refer to group sheets/Kardex for individualized repositioning programs by 8/31/2020. All residents will be reviewed to ensure that their repositioning needs are indicated on the CNA group sheets unless they are independent. Care plans and Kardex□s were updated as well. Date of Compliance: 8/31/2020. Recurrence will be prevented by: Audits of 5 residents□ repositioning plans will be conducted 3x/week x 4, 2x/week x 4, and then weekly x 4 to assure this practice is still appropriate. The results 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/Designee	

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F 686	Continued From page 2	F 686		

breakdown) had been completed, and determination was made that R1 was at risk for skin breakdown. R1's progress notes further indicated R1 had three Stage 2 pressure injuries (partial thickness loss of
dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serumfilled blister) to the outside of the left foot and ankle from resting on the wheelchair footrest, and interventions had been initiated. R1's progress notes additionally indicated R1 was to be turned and repositioned every 2 hours, and checked for bowel incontinence and changed every 2 hours.

R1's care plan reviewed 7/27/20, indicated R1 was at risk for skin breakdown related to impaired mobility and bowel incontinence and had a current pressure injury to left outer foot and ankle. R1's care plan further indicated R1 was incontinent of bowel and directed staff to provide assistance of with perineal cares. R1's care plan lacked directives for frequency of turning and repositioning, and off-loading to prevent skin breakdown.

R1's Kardex/care guide provided 7/28/20, indicated R1 required assistance of two staff for bed mobility and transfers, and was to have elimination needs assessed every 2 hours. R1's group sheets lacked directives for repositioning and off-loading R1.

On 7/28/20, from 3:55 p.m. to 6:43 pm. during continuous observations, R1 had not been off-loaded or significantly repositioned while seated in his wheelchair. Change in position at any time was approximately 15-20 degrees. At 6:43 p.m. nursing assistant (NA)-I and NA-E were

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F 686	Continued From page 3	F 686		

starting to undress and wash up R1 before transferring R1 to bed from the wheelchair. After R1 was transferred to bed, NA-E washed bowel movement from R1's rectal area and buttocks. R1 had no indication of skin breakdown on his buttocks.

On 7/28/20, at 7:03 p.m. NA-I stated everyone is to be repositioned every 2 hours, unless the resident asks more frequently. NA-I stated the repositioning information is not on the group sheets. NA-I stated she usually repositions and toilets everyone when she starts her shift, before dinner, and after dinner.

On 7/28/20, at 7:07 p.m. NA-E verified R1 had not been repositioned or checked and changed since she started her shift at 2:30 p.m. NA-E stated R1 was already up when she started, and usually was in bed, so when she would get him up, he was repositioned at that time. Since R1 was already up, he did not get repositioned or off-loaded. NA-E stated R1 should be repositioned every 2 hours, and verified R1 did not get repositioned in 2 hours on this date.

On 7/29/20, at 9:55 p.m. NA-A stated R1 required total assistance with cares, including toileting and repositioning.

On 7/29/20, at 1:13 p.m. registered nurse (RN)-A verified R1 was to be repositioned every 2 hours, and was at risk for skin breakdown when not repositioned timely. RN-A verified R1's Kardex lacked direction for repositioning R1, but said pretty much everyone is every 2 hours.

On 7/20/20, at 4:00 p.m. the director of nursing (DON) stated there should have been

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F 686	Continued From page 4 communication with shift change as to when R1 got out of bed so staff could reposition him timely. The DON verified R1 was at risk for skin breakdown. The DON stated R could be repositioned in his chair to re-distribute the pressure, and did acknowledge re-distribution was not complete off-loading of pressure. The facility policy Skin Assessment and Wound Management dated 7/18, directed the care plan and care lists be updated with new skin concerns, and care provided according to nursing or physician orders.	F 686		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure implementation	F 688	F688 Increase/Prevent Decrease in ROM/Mobility	8/31/20

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F 688	Continued From page 5 of restorative programs according to the care planned programs for 4 of 4 residents (R1, R2, R4, and R6) reviewed for restorative programs. Findings include: R1 R1's Admission Record printed 7/30/20, indicated R1's diagnoses included hemiplegia and hemiparesis following cerebral infarction (weakness or paralysis on one side of body following a stroke), signs and symptoms involving cognitive functions and awareness, abnormal posture, neuralgia and neuritis (nerve pain), and contracture of hand (fixed tightening of muscle, tendons, or ligaments that prevents normal movement of the affected body part). R1's quarterly Minimum Data Set (MDS) assessment dated 5/4/20, indicated R1 had moderately impaired cognitive skills for daily decision making, had no rejection of care behaviors, and had no restorative programs for 15 minutes over the assessment period. R1's range of motion was not assessed on this assessment. R1's Restorative Nursing Program/Wellness Group POC (plan of care), initiated 6/2/14, indicated R1 was to have passive range of motion (PROM) to all joint of left upper extremity five times weekly, and on 10/17/14, left hand PROM was changed to seven times weekly. R1's Restorative Nursing Program/Wellness Group POC, initiated 5/8/14, indicated R1 was to have heel slides, abduction and adduction, hip internal rotation and gastro with stretch on the right, and left active range of motion (AROM) heel	F 688	Immediate Corrective Action: Resident #1, #2, #4, and #6□s restorative programs were reviewed for continued appropriateness of program. Corrective Action as it applies to others: The Policy and Procedure for Resident Mobility and Range of Motion remains current. All NARs will be re-educated on completing restorative exercises, as well as ensuring appropriate documentation of the exercises by 8/31/2020. The restorative program of each resident will be reviewed monthly by a licensed nurse for continued monitoring of goals, participation, and possibility of alteration 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/week x 4, 2x/week x 4, and then weekly x 4 to ensure programs are completed and documented. The results 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/Designee	

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F 688	Continued From page 6	F 688		

slides and ankle pumps, three times weekly.

A review of R1's restorative documentation indicated R1 was to have PROM to all joints on left, replace splint after hand ROM three times weekly, and monitor splint as needed, and five times weekly right upper extremity PROM. In addition, R1 was to have three times weekly bilateral lower extremity PROM/ assisted AROM to allow feet to be flat on the pedals. R1's restorative documentation further indicated the following:
- From 5/11/20 to 5/17/20, R1's programs were completed 2 of 3 opportunities.
-From 5/18/20 to 5/24/20, R1's programs were completed 3 of 3 opportunities.
- From 5/25/20 to 5/31/20, R1's upper extremity programs were completed 4 days and lower extremity programs were completed 2 of 3 opportunities.
-Documentation for week of 6/1/20 to 6/7/20, was not provided.
-From 6/8/20 to 6/14/20, R1's programs were completed 3 of 3 opportunities.
-From 6/15/20 to 6/21/20, R1's programs were completed 3 of 3 opportunities.
-From 6/22/20 to 6/28/20, R1's programs were completed on upper extremities 3 of 3 opportunities, and for lower extremities, programs were completed 2 of 3 opportunities.
-From 6/29/20 to 7/5/20, R1's programs were completed on upper extremities 3 of 3 opportunities, and for lower extremities, programs were completed 2 of 3 opportunities.
-From 7/6/20, to 7/12/20, R1's programs on upper extremities were completed 2 of 3 opportunities, and for lower extremities, programs were completed 1 of 3 opportunities.
- From 7/13/20 to 7/19/20, R1's programs were

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F 688	Continued From page 7	F 688		

completed 1 of 3 opportunities.
- From 7/20/20 to 7/26/20, R1's programs were completed 2 of 3 opportunities
- No refusals were documented.

A note written by restorative aide/nursing assistant (NA)-J indicated R1 did not refuse treatments and did restorative programs well. NA-J documented blank boxes indicated R1 was not available when approached for therapy or 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.

R2's quarterly MDS dated 4/28/20, indicated R1 had a severe cognitive deficit, required extensive assistance with bed mobility, transfers and ambulation on the unit. R1's MDS further indicated R1 had no restorative programs.

R2's care plan reviewed 7/22/20, directed nursing staff to ambulate R2 two to three times daily as able, with one staff to walk with R2 and one to push the wheelchair behind R2. If R2 refused twice, R2 was to be re-approached at a later time up to three times daily.

R2's Restorative Services Plan of Care dated 1/10/11, indicated R2 was to have 3 of the following: AROM/PROM, upper extremity and hand exercises three times weekly. Another Restorative Service Plan of Care dated 3/22/11, indicated R2 was to have other exercises on lower extremities three times weekly. A third

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F 688	Continued From page 8	F 688		

Restorative Services Plan of Care dated 12/14/18, indicated R1 was to have specific quad exercises three times weekly.

A review of R2's restorative documentation indicated R2 was to have bilateral upper extremity AROM, and exercises as written, three times weekly. In addition R2 was to have quad exercises three times weekly, and bilateral lower extremity exercises as listed three times a week. R2's restorative documentation indicated the following:
- From 5/11/20 to 5/17/20, R2's programs were completed 1 of 3 opportunities.
-From 5/18/20 to 5/24/20, R2's programs were completed 0 of 3 opportunities, R2 refused 2 of those days, and walked instead on the third day.
- From 5/25/20 to 5/31/20, R2's ROM was completed 2 of 3 opportunities, and R2 refused the third opportunity.
-Documentation for week of 6/1/20 to 6/7/20, was not provided.
-From 6/8/20 to 6/14/20, R2's ROM was completed 1 of 3 opportunities and R2 refused 2 days after 3-4 approaches each day.
-From 6/15/20 to 6/21/20, R2's ROM programs was completed 1 of 3 opportunities, and R2 refused 2 days with re-approaches documented one day.
-From 6/22/20 to 6/28/20, R2's ROM was completed 1 of 3 opportunities, and R2 refused two other days.
-From 6/29/20 to 7/5/20, R2's ROM was completed 1 of 3 opportunities, with a refusal one day and "NO" documented the third day.
-From 7/6/20, to 7/12/20, R2's programs were documented refused on 2 of 3 opportunities and blank a third day. R2's Restorative Aide Notes dated 7/6/20 and 7/11/20, provided explanation of

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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 indicated R2 was to ambulate three times daily 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.

On 7/29/20, at 9:55 a.m. NA-A stated the restorative aides do restorative programs and the NA's do not do them.

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On 7/29/20, at 11:34 a.m. restorative aide/NA-C stated R1 did not allow them to do ROM of the left leg, and she reported that to nursing. NA-C stated R1 does ROM programs on hands and right leg fine, and is usually compliant. NA-C stated when clients refuse, they document on another sheet.

On 7/29/20, at 11:42 a.m. the director of nursing (DON) stated the restorative aide is never pulled to work on the unit, but sometimes they do not have a restorative aide. The DON stated they had been in transition with new restorative aides. The DON stated if a resident misses a day of restorative programs, it should be made up another day.

On 7/29/20, at 1:13 p.m. registered nurse (RN)-A stated the nursing assistants would do ROM, or ambulation if the restorative aides were not working that day. RN-A stated they would do the passive ROM. RN-A verified R1 was not allowing ROM of his left lower extremity due to pressure ulcers. RN-A verified R1 did not have a signs off for the nursing assistants to do ROM, so stated he probably had not gotten ROM when the restorative aides were not there, and therefore would have a potential for a decline in ROM.

On 7/29/20, at 2:50 p.m. the DON stated they have restorative meetings, but do not document them. The DON stated they discussed residents' status and any changes, such as increased stiffness or a decline, and then would get therapy orders. The DON stated there were no notes on R1's progress to indicate there was a change in status.

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On 7/29/20, at 3:22 p.m. NA-K stated they know when a resident has a restorative program because it pops up on the computer. NA-K stated they document "not applicable" if it was not done.

On 7/29/20, at 4:08 p.m. the DON stated they have tried different ways of documenting restorative and for R2, the family has a documentation tool for ambulation, also. Having so many different ways and places to document makes it more difficult for staff and difficult to track. The DON stated restorative programs should be on the resident's care plans.

R4

R4's Admission Record dated 7/29/20, indicated R4's diagnoses included dementia without behavioral disturbance and muscle weakness.

R4's annual MDS dated 5/5/20, identified R4' had severely impaired cognition. The MDS further identified R4 did not walk, and had not rejected of care during the seven day look-back period

R4's care plan dated 8/12/19 indicated R4 was unable to ambulate safely due to osteoarthritis and muscle weakness. The care plan directed R4 was to ambulate (walk).

R4's Therapy Communication to Wellness / Restorative Services document dated 12/21/26, directed restorative ambulation was to be performed.

Review of R4's restorative documentation indicated R4 was to be ambulated six times weekly. The restorative documentation further

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indicated
- From 5/11/20 to 5/17/20, R4 was ambulated two of six opportunities.
- From 5/25/20 to 5/31/20, R4 was ambulated four of six opportunities.
- From 7/13/20 to 7/19/20, R4 was ambulated two of six opportunities.
- From 7/20/20 to 7/26/20, R4 was ambulated five of six opportunities.
- No refusals were documented.

R6

R6's Admission Record dated 7/29/20, indicated R6's diagnoses included osteoporosis and abnormal posture.

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.

R6's Restorative Services Plan of Care dated 6/24/19, indicated R6 was to be provided gentle stretches to her hamstrings and ankles related to contractures. The stretches were to be performed three times weekly.

Review of R6's restorative documentation indicated R6 was to have stretching performed to her lower extremities three times weekly. The restorative documentation further indicated:
- From 5/11/20 to 5/17/20, R6's stretching was performed one of three opportunities.
- From 5/25/20 to 5/31/20, R6's stretching was performed two of three opportunities.
- From 6/29/20 to 7/5/20, R6's stretching was performed one of three opportunities.
- From 7/13/20 to 7/19/20, R6's stretching was

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not performed.
- No refusals were documented.

On 7/29/20, at 11:45 a.m., R4's restorative documentation was reviewed with nursing assistant (NA)-C. NA-C confirmed no documentation existed which indicated R4 refused ambulation and stated "she probably didn't get walked." NA-C stated there were two restorative aides recently hired. NA-C stated she believed no one performed restorative cares when restorative aides were not scheduled.

On 7/29/20, at 12:08 p.m. an interview was conducted with the DON. The DON stated nursing staff walked residents when restorative aides were not scheduled. The DON stated lists were placed at each nurses' station so staff knew which residents needed to get walked. The DON stated NAs' were not allowed to perform stretching as they were not trained by therapy. The DON stated restorative aides were scheduled daily, however, there may be a day in which no one was scheduled due to training. The DON stated staff documented refusals on therapy progress notes. The DON stated if no progress note existed it was likely a resident did not refuse care.

On 7/29/20, at 12:26 p.m. an interview was conducted with RN-B. RN-B stated nursing staff performed restorative cares when restorative aides were not available. RN-B stated nursing staff performed gentle stretching and walked residents. RN-B stated nursing staff documented when residents were walked, but not stretched.

On 7/29/20, at 1:07 p.m. an interview was conducted with the DON. The DON stated two

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restorative aides resigned when COVID-19 started.

On 7/29/20, at 3:08 p.m. an interview was conducted with NA-F. NA-F stated a document was at the nurses' station which indicated what restorative cares needed to be completed. The document was reviewed, with NA-F and NA-F confirmed the restorative sheet lacked indication R4 needed to be walked.

On 7/29/20, at 3:08 p.m. an interview was conducted with NA-H. NA-H stated the unit manager placed a list at the nurses' station which indicated which residents were on restorative programs. NA-H stated R4 was on a walking program and she usually ambulated five to 15 feet. NA-H was asked how nursing staff was made aware when restorative cares were not completed. NA-H stated staff assumed R4's walking was getting done. NA-H stated the restorative aides' documentation was locked in the restorative office afterhours.

On 7/29/20, at 3:32 p.m. an interview was conducted with the DON. The DON stated the facility restorative program was a work in-progress. The DON stated she recently started oversight of the program and there wasn't a good hand off.

On 7/29/20, at 3:53 p.m. an interview was conducted with the DON. The DON stated staff were expected to follow resident restorative treatment plans. The DON stated she needed to check the record to see what R6's restorative plan included. The DON stated she did not know if R4 and R6 refused restorative cares, but had not heard their names a lot.

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F 688	Continued From page 15 Facility policy Resident Mobility and Range of Motion dated 7/17, directed, "Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM." The policy further directed, "Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable."	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 690		8/31/20

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F 690	Continued From page 16 continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely incontinence cares were provided for 2 of 3 residents (R4, R1) reviewed for bowel and bladder incontinence. Findings include: R4's Admission Record dated 7/29/20, indicated R4's diagnoses included dementia without behavioral disturbance, heart failure and muscle weakness. R4's annual Minimum Data Set (MDS) dated 5/5/20, identified R4 had severely impaired cognition. R4's MDS further identified she required extensive assistance toileting, had an ostomy, and was always incontinent of bladder. R4's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 5/8/20, indicated R4 had urinary incontinence, and her elimination needs were to be assessed every two hours. R4's Kardex dated 7/24/17, indicated R4 was incontinent of bladder and had an ostomy. The Kardex directed staff to assess elimination needs,	F 690	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 incontinent cares per their schedule. NAR-E, NAR-G, and NAR-I were educated on need to complete resident toileting cares per NAR care sheet. Corrective Action as it applies to others: The Policy and Procedure for Activities of Daily Living remains current. All NARs will be re-educated on completing resident toileting cares per NAR care sheet by 8/31/2020. All residents will be reviewed to ensure to that their toileting needs are on the NAR care sheets. Date of Compliance: 8/31/2020. Recurrence will be prevented by: Audits of 5 residents will be conducted 3x/week x 4, 2x/week x 4, and then weekly x 4 to ensure that their toileting needs are completed timely. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the	

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F 690	Continued From page 17 and check for incontinence, every two hours during the day and rounds during the night. The Kardex further directed staff to check R4's ostomy every two hours. On 7/28/20, at 3:45 p.m. R4 was observed in her room, and she was seated in a wheelchair. R4 was facing a nightstand, near her bed, and was holding a call light in her left hand. On 7/28/20, at 3:47 p.m. R4's call light was observed to be on. Nursing assistant (NA)-G entered R4's room, within the minute, and closed the door. NA-G exited the R4's room at 3:58 p.m. R4's door was left open and she was observed seated in a wheelchair, and was facing a nightstand near her bed. On 7/28/20, at 4:17 p.m. an unidentified staff person entered R4's with medications. The staff person administered medications to R4 and exited the room within a minute. At 4:19 p.m. the unidentified staff person again entered R4's room. The staff person administered eye drops to R4. The staff-person exited R4's room at 4:20 p.m. The resident remained seated in a wheelchair and faced a nightstand near her bed. On 7/28/20, at 5:09 p.m. R4 was wheeled to the dining room. At 6:12 p.m. NA-F approached R4 and asked if she was finished eating. R4 continued to eat. At 6:22 p.m. NA-F placed a chair near R4 and inquired how she was doing. NA-F stated, "Go ahead and finish eating." NA-F then walked away from R4. At 6:24 p.m. NA-F again sat near R4 and encouraged her to drink fluids. At 6:35 p.m. NA-F wheeled R4 from the dining room to her room. NA-F then exited R4's room.	F 690	audits. Corrections will be monitored by: DON/ADON/Nurse Managers/Designee	

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On 7/28/20, at 7:06 p.m. an interview was conducted with NA-F. NA-F stated R4 was not usually incontinent, but she didn't work with the resident much. NA-F stated she was unsure if R4 was on a check and change schedule. NA-F stated in general, residents were to be checked and changed every two hours. NA-F stated R4 had an ostomy, and staff were to check it every two hours. NA-F stated she was unsure when R4's ostomy was last checked.

On 7/28/20, at approximately 7:30 p.m. an interview was conducted with NA-G. NA-G stated R4 required stand by assistance when she was transferred or toileted. NA-G stated R4 was continent "sometimes." NA-G stated R4 had an ostomy and it needed to be emptied every two hours. NA-G stated R4 also needed to be checked-and-changed every two hours. NA-G stated she emptied R4's ostomy at 6:30 p.m. At this time, R4's ostomy pouch was observed with NA-G. R4's ostomy pouch was filled with air and NA-G stated it needed to be "burped" (release air from ostomy pouch). NA-G then released the air from the ostomy pouch. NA-G confirmed R4's ostomy pouch was approximately one-half full with light brown stool. NA-G also confirmed R4's incontinence product was "wet." NA-G stated she would "normally" change a resident's incontinence product, however, she needed to clean the shower room because another resident was waiting to use it. NA-G then exited R4's room. NA-G stated she did not document when R4's ostomy pouch was last emptied.

On 7/29/20, at 12:26 p.m. an interview was conducted with registered nurse (RN)-B. RN-B stated R4 was normally incontinent and also had

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an ostomy. RN-B stated staff were expected to check-and-change R4 every two hours, during the day, and rounds during night shift. RN-B stated you wound not normally expect an ostomy pouch to be one-half full of stool in an hour. RN-B stated staff would be expected to change a resident's incontinence product if it was identified to be wet. RN-B stated a resident could have skin breakdown or develop a urinary tract infection if an incontinence product was not changed when soiled.

On 7/29/20, at 3:53 p.m. an interview was conducted with the director of nursing (DON). The DON stated R4 was incontinent of urine, and had an ostomy which she didn't empty herself. The DON stated staff were supposed to check and change R4 every two hours. The DON stated she would had expected staff to delay the shower and care for the resident when her incontinence product was identified to be wet.

Facility policy titled Activities of Daily Living (ADLs), Supporting dated 3/18, directed, "Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care ..."

R1's Admission Record printed 7/30/20, indicated R2's diagnoses included hemiplegia and hemiparesis following cerebral infarction (weakness or paralysis on one side of body following a stroke), signs and symptoms involving cognitive functions and awareness, abnormal posture, neuralgia and neuritis (nerve pain), and

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contracture of hand (fixed tightening of muscle, tendons, or ligaments that prevents normal movement of the affected body part).

R1's quarterly MDS dated 5/4/20, indicated R1 had moderately impaired 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, 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 hours.

R1's care plan reviewed 7/27/20, indicated R1 was incontinent of bowel and directed staff to provide incontinent care after each incontinent bowel movement. R1's care plan lacked directives for frequency of checking and changing.

R1's Kardex/care guide provided 7/28/20, indicated R1 had a urinary catheter, required assistance of 2 staff for perineal care and was to be assessed for elimination needs or checked for incontinence every 2 hours.

On 7/28/20, from 3:55 p.m. to 6:43 pm. during continuous observations, R1 had not been checked for incontinence or changed. At 6:43 p.m. NA-I and NA-E were starting to undress and wash up R1 before transferring R1 to bed from the wheelchair. After R1 was transferred to bed, NA-E washed bowel movement from R1's rectal

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F 690	Continued From page 21 area and buttocks. R1 had no indication of skin breakdown on his buttocks. On 7/28/20, at 7:07 p.m. NA-E verified R1 had not been repositioned or checked and changed since she started her shift at 2:30 p.m. NA-E stated R1 was already up when she started, and usually was in bed, so when she would get him up, he would be repositioned and changed at that time. Since R1 was already up, he did not get repositioned or changed. NA-E stated R1 should be repositioned and checked or changed every 2 hours, and verified R1 did not get repositioned or checked in 2 hours on this date. On 7/29/20, at 9:55 p.m. NA-A stated R1 required total assistance with cares, including toileting and repositioning. On 7/29/20, at 1:13 p.m. RN-A verified R1 was to be checked and changed every 2 hours, and was at risk for skin breakdown. RN-A verified R1's Kardex directed to check and change every 2 hours. On 7/20/20, at 4:00 p.m. the director of nursing (DON) stated there should have been communication with shift change as to when R1 got out of bed so staff could reposition and check for incontinence timely. The DON verified R1 was at risk for skin breakdown.	F 690		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		8/31/20

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	245283	A. BUILDING _____ B. WING _____	C 07/29/2020

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F 880	Continued From page 22	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 880	Continued From page 23 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene during personal cares to prevent cross contamination for 1 of 2 residents (R1) observed during incontinent cares. Findings include: R1's Admission Record printed 7/30/20, indicated R2's diagnoses included hemiplegia and hemiparesis following cerebral infarction (weakness or paralysis on one side of body following a stroke), signs and symptoms involving cognitive functions and awareness, abnormal posture, neuralgia and neuritis (nerve pain), and contracture of hand (fixed tightening of muscle,	F 880	F880 Infection Prevention & Control Immediate Corrective Action: NA-E received education on the proper process for sanitizing/washing her hands. Corrective Action as it applies to others: All residents are at risk to potentially be affected. Policies/Procedures/System Changes The facility□s QAPI committee conducted a root cause analysis to identify the problem(s) that resulted in this deficient practice, and develop an intervention and corrective action plan to prevent recurrence. The Policy and Procedure for Hand Hygiene was reviewed by DON/IP and	

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F 880	Continued From page 24 tendons, or ligaments that prevents normal movement of the affected body part). R1's quarterly Minimum Data Set (MDS) dated 5/4/20, indicated R1 had moderately impaired 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, 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 hours. R1's care plan reviewed 7/27/20, indicated R1 was incontinent of bowel, and directed staff to provide incontinent care after each incontinent bowel movement. R1's care plan lacked directives for frequency of checking and changing. R1's Kardex/care guide provided 7/28/20, indicated R1 had a urinary catheter, required assistance of 2 staff for perineal care and was to be assessed for elimination needs or checked for incontinence every 2 hours. On 7/28/20, at 6:43 p.m. nursing assistant (NA)-I and NA-E were starting to undress and wash up R1 before transferring R1 to bed from the wheelchair. NA-E and NA-I had washed hands and donned gloves. After R1 was transferred to bed, NA-I lowered R1's incontinent brief, and NA-E washed and rinsed R1's perineal area, and R1 was turned to the left. NA-E washed bowel	F 880	remains current. Training Education All NAR□s were educated on hand hygiene while completing peri care, by 8/31/2020. All staff were educated on hand hygiene. Hand hygiene education included a post test that measured competency by 9/92020 Recurrence will be prevented by: The Director of Nursing, the Infection Preventionist and other facility leadership will conduct audits on all shifts, every day for one week, then may decrease the frequency based upon compliance. Audits should continue until 100% compliance is met. The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program. Corrections will be monitored by: DON/ADON/Nurse Managers/Designee	

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F 880	Continued From page 25	F 880		

movement from R1's rectal area and lower buttocks. NA-E then opened and applied ointment to R1's buttocks and rectal area. NA-E removed the soiled gloves, and without performing hand hygiene positioned and put a clean incontinent brief on R1. NA-E and NA-I turned R1 to his back and slightly to the right to remove the hoyer canvas from under him. NA-E moved the canvas and placed it on R1's wheelchair. NA-E put pillow cases on a pillow, and put it under R1's calves. NA-E then put R1's call light within his reach, and raised R1's head of the bed. NA-E then washed her hands in R1's bathroom before exiting the room. NA-E had not performed hand hygiene after removing her soiled gloves following incontinent cares, and before touching clean items.

On 7/28/20, at 7:07 p.m. NA-E verified she had performed hand hygiene after removing gloves following perineal cares, and before touching clean items. NA-E stated she was not sure when to sanitize or wash her hands.

On 7/29/20, at 1:13 p.m. registered nurse (RN)-A stated the expectation was for hand hygiene to be done before cares, after perineal cares, and going from dirty to clean tasks. RN-A stated staff should remove gloves and sanitize, and reglove going from dirty to clean tasks.

On 7/20/20, at 4:00 p.m. the director of nursing (DON) stated staff should change gloves, and perform hand hygiene when going from soiled to clean, before continuing another task.

The facility policy Hand Hygiene dated 6/17, directed infection control begins with hand hygiene and would reduce the spread of

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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 urinals, and after removing gloves.	F 880		

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/28/20, through 7/29/20, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found to be NOT IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5283025C, H5238026C, H5283027C, H5283028C, and H5283029C. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form.	2 000		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure implementation of restorative programs according to the care planned programs for 4 of 4 residents (R1, R2, R4, and R6) reviewed for restorative programs. Findings include: R1 R1's Admission Record printed 7/30/20, indicated	2 890	F688 Increase/Prevent Decrease in ROM/Mobility Immediate Corrective Action: Resident #1, #2, #4, and #6□s restorative programs were reviewed for continued appropriateness of program. Corrective Action as it applies to others: The Policy and Procedure for Resident Mobility and Range of Motion remains current.	8/31/20

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2 890	Continued From page 2 R1's diagnoses included hemiplegia and hemiparesis following cerebral infarction (weakness or paralysis on one side of body following a stroke), signs and symptoms involving cognitive functions and awareness, abnormal posture, neuralgia and neuritis (nerve pain), and contracture of hand (fixed tightening of muscle, tendons, or ligaments that prevents normal movement of the affected body part). R1's quarterly Minimum Data Set (MDS) assessment dated 5/4/20, indicated R1 had moderately impaired cognitive skills for daily decision making, had no rejection of care behaviors, and had no restorative programs for 15 minutes over the assessment period. R1's range of motion was not assessed on this assessment. R1's Restorative Nursing Program/Wellness Group POC (plan of care), initiated 6/2/14, indicated R1 was to have passive range of motion (PROM) to all joint of left upper extremity five times weekly, and on 10/17/14, left hand PROM was changed to seven times weekly. R1's Restorative Nursing Program/Wellness Group POC, initiated 5/8/14, indicated R1 was to have heel slides, abduction and adduction, hip internal rotation and gastro with stretch on the right, and left active range of motion (AROM) heel slides and ankle pumps, three times weekly. A review of R1's restorative documentation indicated R1 was to have PROM to all joints on left, replace splint after hand ROM three times weekly, and monitor splint as needed, and five times weekly right upper extremity PROM. In addition, R1 was to have three times weekly bilateral lower extremity PROM/ assisted AROM	2 890	All NARs will be re-educated on completing restorative exercises, as well as ensuring appropriate documentation of the exercises by 8/31/2020. The restorative program of each resident will be reviewed monthly by a licensed nurse for continued monitoring of goals, participation, and possibility of alteration 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/week x 4, 2x/week x 4, and then weekly x 4 to ensure programs are completed and documented. The results 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/Designee	

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2 890	Continued From page 3 to allow feet to be flat on the pedals. R1's restorative documentation further indicated the following: - From 5/11/20 to 5/17/20, R1's programs were completed 2 of 3 opportunities. -From 5/18/20 to 5/24/20, R1's programs were completed 3 of 3 opportunities. - From 5/25/20 to 5/31/20, R1's upper extremity programs were completed 4 days and lower extremity programs were completed 2 of 3 opportunities. -Documentation for week of 6/1/20 to 6/7/20, was not provided. -From 6/8/20 to 6/14/20, R1's programs were completed 3 of 3 opportunities. -From 6/15/20 to 6/21/20, R1's programs were completed 3 of 3 opportunities. -From 6/22/20 to 6/28/20, R1's programs were completed on upper extremities 3 of 3 opportunities, and for lower extremities, programs were completed 2 of 3 opportunities. -From 6/29/20 to 7/5/20, R1's programs were completed on upper extremities 3 of 3 opportunities, and for lower extremities, programs were completed 2 of 3 opportunities. -From 7/6/20, to 7/12/20, R1's programs on upper extremities were completed 2 of 3 opportunities, and for lower extremities, programs were completed 1 of 3 opportunities. - From 7/13/20 to 7/19/20, R1's programs were completed 1 of 3 opportunities. - From 7/20/20 to 7/26/20, R1's programs were completed 2 of 3 opportunities - No refusals were documented. A note written by restorative aide/nursing assistant (NA)-J indicated R1 did not refuse treatments and did restorative programs well. NA-J documented blank boxes indicated R1 was not available when approached for therapy or	2 890		

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2 890	Continued From page 4 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. R2's quarterly MDS dated 4/28/20, indicated R1 had a severe cognitive deficit, required extensive assistance with bed mobility, transfers and ambulation on the unit. R1's MDS further indicated R1 had no restorative programs. R2's care plan reviewed 7/22/20, directed nursing staff to ambulate R2 two to three times daily as able, with one staff to walk with R2 and one to push the wheelchair behind R2. If R2 refused twice, R2 was to be re-approached at a later time up to three times daily. R2's Restorative Services Plan of Care dated 1/10/11, indicated R2 was to have 3 of the following: AROM/PROM, upper extremity and hand exercises three times weekly. Another Restorative Service Plan of Care dated 3/22/11, indicated R2 was to have other exercises on lower extremities three times weekly. A third Restorative Services Plan of Care dated 12/14/18, indicated R1 was to have specific quad exercises three times weekly. A review of R2's restorative documentation indicated R2 was to have bilateral upper extremity AROM, and exercises as written, three times weekly. In addition R2 was to have quad exercises three times weekly, and bilateral lower extremity exercises as listed three times a week. R2's restorative documentation indicated the	2 890		

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2 890	Continued From page 5 following: - From 5/11/20 to 5/17/20, R2's programs were completed 1 of 3 opportunities. -From 5/18/20 to 5/24/20, R2's programs were completed 0 of 3 opportunities, R2 refused 2 of those days, and walked instead on the third day. - From 5/25/20 to 5/31/20, R2's ROM was completed 2 of 3 opportunities, and R2 refused the third opportunity. -Documentation for week of 6/1/20 to 6/7/20, was not provided. -From 6/8/20 to 6/14/20, R2's ROM was completed 1 of 3 opportunities and R2 refused 2 days after 3-4 approaches each day. -From 6/15/20 to 6/21/20, R2's ROM programs was completed 1 of 3 opportunities, and R2 refused 2 days with re-approaches documented one day. -From 6/22/20 to 6/28/20, R2's ROM was completed 1 of 3 opportunities, and R2 refused two other days. -From 6/29/20 to 7/5/20, R2's ROM was completed 1 of 3 opportunities, with a refusal one day and "NO" documented the third day. -From 7/6/20, to 7/12/20, R2's programs were documented refused on 2 of 3 opportunities and blank a third day. R2's Restorative Aide Notes dated 7/6/20 and 7/11/20, provided explanation of 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 indicated R2 was to ambulate three times daily with a wheelchair pulled behind for safety and	2 890		

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2 890	Continued From page 6 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. On 7/29/20, at 9:55 a.m. NA-A stated the restorative aides do restorative programs and the NA's do not do them. On 7/29/20, at 11:34 a.m. restorative aide/NA-C stated R1 did not allow them to do ROM of the left leg, and she reported that to nursing. NA-C stated R1 does ROM programs on hands and right leg fine, and is usually compliant. NA-C stated when clients refuse, they document on another sheet. On 7/29/20, at 11:42 a.m. the director of nursing (DON) stated the restorative aide is never pulled to work on the unit, but sometimes they do not have a restorative aide. The DON stated they had	2 890		

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2 890	Continued From page 7 been in transition with new restorative aides. The DON stated if a resident misses a day of restorative programs, it should be made up another day. On 7/29/20, at 1:13 p.m. registered nurse (RN)-A stated the nursing assistants would do ROM, or ambulation if the restorative aides were not working that day. RN-A stated they would do the passive ROM. RN-A verified R1 was not allowing ROM of his left lower extremity due to pressure ulcers. RN-A verified R1 did not have a signs off for the nursing assistants to do ROM, so stated he probably had not gotten ROM when the restorative aides were not there, and therefore would have a potential for a decline in ROM. On 7/29/20, at 2:50 p.m. the DON stated they have restorative meetings, but do not document them. The DON stated they discussed residents' status and any changes, such as increased stiffness or a decline, and then would get therapy orders. The DON stated there were no notes on R1's progress to indicate there was a change in status. On 7/29/20, at 3:22 p.m. NA-K stated they know when a resident has a restorative program because it pops up on the computer. NA-K stated they document "not applicable" if it was not done. On 7/29/20, at 4:08 p.m. the DON stated they have tried different ways of documenting restorative and for R2, the family has a documentation tool for ambulation, also. Having so many different ways and places to document makes it more difficult for staff and difficult to track. The DON stated restorative programs should be on the resident's care plans.	2 890		

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2 890	Continued From page 8 R4 R4's Admission Record dated 7/29/20, indicated R4's diagnoses included dementia without behavioral disturbance and muscle weakness. R4's annual MDS dated 5/5/20, identified R4' had severely impaired cognition. The MDS further identified R4 did not walk, and had not rejected of care during the seven day look-back period R4's care plan dated 8/12/19 indicated R4 was unable to ambulate safely due to osteoarthritis and muscle weakness. The care plan directed R4 was to ambulate (walk). R4's Therapy Communication to Wellness / Restorative Services document dated 12/21/26, directed restorative ambulation was to be performed. Review of R4's restorative documentation indicated R4 was to be ambulated six times weekly. The restorative documentation further indicated - From 5/11/20 to 5/17/20, R4 was ambulated two of six opportunities. - From 5/25/20 to 5/31/20, R4 was ambulated four of six opportunities. - From 7/13/20 to 7/19/20, R4 was ambulated two of six opportunities. - From 7/20/20 to 7/26/20, R4 was ambulated five of six opportunities. - No refusals were documented. R6 R6's Admission Record dated 7/29/20, indicated R6's diagnoses included osteoporosis and abnormal posture.	2 890		

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2 890	Continued From page 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.

R6's Restorative Services Plan of Care dated 6/24/19, indicated R6 was to be provided gentle stretches to her hamstrings and ankles related to contractures. The stretches were to be performed three times weekly.

Review of R6's restorative documentation indicated R6 was to have stretching performed to her lower extremities three times weekly. The restorative documentation further indicated:
- From 5/11/20 to 5/17/20, R6's stretching was performed one of three opportunities.
- From 5/25/20 to 5/31/20, R6's stretching was performed two of three opportunities.
- From 6/29/20 to 7/5/20, R6's stretching was performed one of three opportunities.
- From 7/13/20 to 7/19/20, R6's stretching was not performed.
- No refusals were documented.

On 7/29/20, at 11:45 a.m., R4's restorative documentation was reviewed with nursing assistant (NA)-C. NA-C confirmed no documentation existed which indicated R4 refused ambulation and stated "she probably didn't get walked." NA-C stated there were two restorative aides recently hired. NA-C stated she believed no one performed restorative cares when restorative aides were not scheduled.

On 7/29/20, at 12:08 p.m. an interview was conducted with the DON. The DON stated nursing staff walked residents when restorative aides were not scheduled. The DON stated lists

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2 890	Continued From page 10	2 890		

were placed at each nurses' station so staff knew which residents needed to get walked. The DON stated NAs' were not allowed to perform stretching as they were not trained by therapy. The DON stated restorative aides were scheduled daily, however, there may be a day in which no one was scheduled due to training. The DON stated staff documented refusals on therapy progress notes. The DON stated if no progress note existed it was likely a resident did not refuse care.

On 7/29/20, at 12:26 p.m. an interview was conducted with RN-B. RN-B stated nursing staff performed restorative cares when restorative aides were not available. RN-B stated nursing staff performed gentle stretching and walked residents. RN-B stated nursing staff documented when residents were walked, but not stretched.

On 7/29/20, at 1:07 p.m. an interview was conducted with the DON. The DON stated two restorative aides resigned when COVID-19 started.

On 7/29/20, at 3:08 p.m. an interview was conducted with NA-F. NA-F stated a document was at the nurses' station which indicated what restorative cares needed to be completed. The document was reviewed, with NA-F and NA-F confirmed the restorative sheet lacked indication R4 needed to be walked.

On 7/29/20, at 3:08 p.m. an interview was conducted with NA-H. NA-H stated the unit manager placed a list at the nurses' station which indicated which residents were on restorative programs. NA-H stated R4 was on a walking program and she usually ambulated five to 15 feet. NA-H was asked how nursing staff was

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made aware when restorative cares were not completed. NA-H stated staff assumed R4's walking was getting done. NA-H stated the restorative aides' documentation was locked in the restorative office afterhours.

On 7/29/20, at 3:32 p.m. an interview was conducted with the DON. The DON stated the facility restorative program was a work in-progress. The DON stated she recently started oversight of the program and there wasn't a good hand off.

On 7/29/20, at 3:53 p.m. an interview was conducted with the DON. The DON stated staff were expected to follow resident restorative treatment plans. The DON stated she needed to check the record to see what R6's restorative plan included. The DON stated she did not know if R4 and R6 refused restorative cares, but had not heard their names a lot.

Facility policy Resident Mobility and Range of Motion dated 7/17, directed, "Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM." The policy further directed, "Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable."

SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could develop and implement policies and procedures related to the facility restorative program. The DON, or designee, could provide training for all nursing staff related to the policies and procedures. The quality assessment and assurance committee could perform random

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2 890	Continued From page 12 audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure repositioning and off-loading of pressure according to the care plan to prevent development of pressure ulcers for 1 of 3 residents (R1) reviewed for repositioning. Findings include: R1's Admission Record printed 7/30/20, indicated R1's diagnoses included hemiplegia and	2 900	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. Corrective Action as it applies to others: The Policy and Procedure for Skin Assessment and Wound Management remains current. All licensed nurses and NARs will be	8/31/20

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2 900	Continued From page 13 hemiparesis following cerebral infarction (weakness or paralysis on one side of body following a stroke), signs and symptoms involving cognitive functions and awareness, abnormal posture, neuralgia and neuritis (nerve pain), and contracture of hand (fixed tightening of muscle, tendons, or ligaments that prevents normal movement of the affected body part). R1's quarterly Minimum Data Set (MDS) dated 5/4/20, indicated R1 had moderately impaired 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 staff for transfers, extensive assist of one staff for toileting cares, and was always incontinent of bowel. R1's MDS further indicated R1 had no pressure ulcers, and had a pressure reducing device in chair and bed. R1's quarterly review progress notes dated 7/27/20, indicated a Braden Scale assessment (tool to assist in determining risk of skin breakdown) had been completed, and determination was made that R1 was at risk for skin breakdown. R1's progress notes further indicated R1 had three Stage 2 pressure injuries (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serumfilled blister) to the outside of the left foot and ankle from resting on the wheelchair footrest, and interventions had been initiated. R1's progress notes additionally indicated R1 was to be turned and repositioned every 2 hours, and checked for bowel incontinence and changed every 2 hours. R1's care plan reviewed 7/27/20, indicated R1 was at risk for skin breakdown related to impaired	2 900	re-educated on the need to refer to group sheets/Kardex for individualized repositioning programs by 8/31/2020. All residents will be reviewed to ensure that their repositioning needs are indicated on the CNA group sheets unless they are independent. Care plans and Kardex□s were updated as well. Date of Compliance: 8/31/2020. Recurrence will be prevented by: Audits of 5 residents□ repositioning plans will be conducted 3x/week x 4, 2x/week x 4, and then weekly x 4 to assure this practice is still appropriate. The results 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/Designee	

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mobility and bowel incontinence and had a current pressure injury to left outer foot and ankle. R1's care plan further indicated R1 was incontinent of bowel and directed staff to provide assistance of with perineal cares. R1's care plan lacked directives for frequency of turning and repositioning, and off-loading to prevent skin breakdown.

R1's Kardex/care guide provided 7/28/20, indicated R1 required assistance of two staff for bed mobility and transfers, and was to have elimination needs assessed every 2 hours. R1's group sheets lacked directives for repositioning and off-loading R1.

On 7/28/20, from 3:55 p.m. to 6:43 pm. during continuous observations, R1 had not been off-loaded or significantly repositioned while seated in his wheelchair. Change in position at any time was approximately 15-20 degrees. At 6:43 p.m. nursing assistant (NA)-I and NA-E were starting to undress and wash up R1 before transferring R1 to bed from the wheelchair. After R1 was transferred to bed, NA-E washed bowel movement from R1's rectal area and buttocks. R1 had no indication of skin breakdown on his buttocks.

On 7/28/20, at 7:03 p.m. NA-I stated everyone is to be repositioned every 2 hours, unless the resident asks more frequently. NA-I stated the repositioning information is not on the group sheets. NA-I stated she usually repositions and toilets everyone when she starts her shift, before dinner, and after dinner.

On 7/28/20, at 7:07 p.m. NA-E verified R1 had not been repositioned or checked and changed since she started her shift at 2:30 p.m. NA-E

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2 900	Continued From page 15 stated R1 was already up when she started, and usually was in bed, so when she would get him up, he was repositioned at that time. Since R1 was already up, he did not get repositioned or off-loaded. NA-E stated R1 should be repositioned every 2 hours, and verified R1 did not get repositioned in 2 hours on this date. On 7/29/20, at 9:55 p.m. NA-A stated R1 required total assistance with cares, including toileting and repositioning. On 7/29/20, at 1:13 p.m. registered nurse (RN)-A verified R1 was to be repositioned every 2 hours, and was at risk for skin breakdown when not repositioned timely. RN-A verified R1's Kardex lacked direction for repositioning R1, but said pretty much everyone is every 2 hours. On 7/20/20, at 4:00 p.m. the director of nursing (DON) stated there should have been communication with shift change as to when R1 got out of bed so staff could reposition him timely. The DON verified R1 was at risk for skin breakdown. The DON stated R could be repositioned in his chair to re-distribute the pressure, and did acknowledge re-distribution was not complete off-loading of pressure. The facility policy Skin Assessment and Wound Management dated 7/18, directed the care plan and care lists be updated with new skin concerns, and care provided according to nursing or physician orders. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers	2 900		

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2 900	Continued From page 16 from developing and to promote healing of pressure ulcers. The director of nursing, or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely incontinence cares were provided for 2 of 3 residents (R4, R1) reviewed for bowel and bladder incontinence.	2 910	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	8/31/20

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2 910	Continued From page 17 Findings include: R4's Admission Record dated 7/29/20, indicated R4's diagnoses included dementia without behavioral disturbance, heart failure and muscle weakness. R4's annual Minimum Data Set (MDS) dated 5/5/20, identified R4 had severely impaired cognition. R4's MDS further identified she required extensive assistance toileting, had an ostomy, and was always incontinent of bladder. R4's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 5/8/20, indicated R4 had urinary incontinence, and her elimination needs were to be assessed every two hours. R4's Kardex dated 7/24/17, indicated R4 was incontinent of bladder and had an ostomy. The Kardex directed staff to assess elimination needs, and check for incontinence, every two hours during the day and rounds during the night. The Kardex further directed staff to check R4's ostomy every two hours. On 7/28/20, at 3:45 p.m. R4 was observed in her room, and she was seated in a wheelchair. R4 was facing a nightstand, near her bed, and was holding a call light in her left hand. On 7/28/20, at 3:47 p.m. R4's call light was observed to be on. Nursing assistant (NA)-G entered R4's room, within the minute, and closed the door. NA-G exited the R4's room at 3:58 p.m. R4's door was left open and she was observed seated in a wheelchair, and was facing a nightstand near her bed.	2 910	incontinent cares per their schedule. NAR-E, NAR-G, and NAR-I were educated on need to complete resident toileting cares per NAR care sheet. Corrective Action as it applies to others: The Policy and Procedure for Activities of Daily Living remains current. All NARs will be re-educated on completing resident toileting cares per NAR care sheet by 8/31/2020. All residents will be reviewed to ensure to that their toileting needs are on the NAR care sheets. Date of Compliance: 8/31/2020. Recurrence will be prevented by: Audits of 5 residents will be conducted 3x/week x 4, 2x/week x 4, and then weekly x 4 to ensure that their toileting needs are completed timely. The results 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/Designee	

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	00582	A. BUILDING: _____ B. WING _____	C 07/29/2020

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2 910	Continued From page 18 On 7/28/20, at 4:17 p.m. an unidentified staff person entered R4's with medications. The staff person administered medications to R4 and exited the room within a minute. At 4:19 p.m. the unidentified staff person again entered R4's room. The staff person administered eye drops to R4. The staff-person exited R4's room at 4:20 p.m. The resident remained seated in a wheelchair and faced a nightstand near her bed. On 7/28/20, at 5:09 p.m. R4 was wheeled to the dining room. At 6:12 p.m. NA-F approached R4 and asked if she was finished eating. R4 continued to eat. At 6:22 p.m. NA-F placed a chair near R4 and inquired how she was doing. NA-F stated, "Go ahead and finish eating." NA-F then walked away from R4. At 6:24 p.m. NA-F again sat near R4 and encouraged her to drink fluids. At 6:35 p.m. NA-F wheeled R4 from the dining room to her room. NA-F then exited R4's room. On 7/28/20, at 7:06 p.m. an interview was conducted with NA-F. NA-F stated R4 was not usually incontinent, but she didn't work with the resident much. NA-F stated she was unsure if R4 was on a check and change schedule. NA-F stated in general, residents were to be checked and changed every two hours. NA-F stated R4 had an ostomy, and staff were to check it every two hours. NA-F stated she was unsure when R4's ostomy was last checked. On 7/28/20, at approximately 7:30 p.m. an interview was conducted with NA-G. NA-G stated R4 required stand by assistance when she was transferred or toileted. NA-G stated R4 was continent "sometimes." NA-G stated R4 had an ostomy and it needed to be emptied every two hours. NA-G stated R4 also needed to be	2 910		

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2 910	Continued From page 19	2 910		

checked-and-changed every two hours. NA-G stated she emptied R4's ostomy at 6:30 p.m. At this time, R4's ostomy pouch was observed with NA-G. R4's ostomy pouch was filled with air and NA-G stated it needed to be "burped" (release air from ostomy pouch). NA-G then released the air from the ostomy pouch. NA-G confirmed R4's ostomy pouch was approximately one-half full with light brown stool. NA-G also confirmed R4's incontinence product was "wet." NA-G stated she would "normally" change a resident's incontinence product, however, she needed to clean the shower room because another resident was waiting to use it. NA-G then exited R4's room. NA-G stated she did not document when R4's ostomy pouch was last emptied.

On 7/29/20, at 12:26 p.m. an interview was conducted with registered nurse (RN)-B. RN-B stated R4 was normally incontinent and also had an ostomy. RN-B stated staff were expected to check-and-change R4 every two hours, during the day, and rounds during night shift. RN-B stated you wound not normally expect an ostomy pouch to be one-half full of stool in an hour. RN-B stated staff would be expected to change a resident's incontinence product if it was identified to be wet. RN-B stated a resident could have skin breakdown or develop a urinary tract infection if an incontinence product was not changed when soiled.

On 7/29/20, at 3:53 p.m. an interview was conducted with the director of nursing (DON). The DON stated R4 was incontinent of urine, and had an ostomy which she didn't empty herself. The DON stated staff were supposed to check and change R4 every two hours. The DON stated she would had expected staff to delay the shower and care for the resident when her

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2 910	Continued From page 20 incontinence product was identified to be wet. Facility policy titled Activities of Daily Living (ADLs), Supporting dated 3/18, directed, "Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care ..." R1's Admission Record printed 7/30/20, indicated R2's diagnoses included hemiplegia and hemiparesis following cerebral infarction (weakness or paralysis on one side of body following a stroke), signs and symptoms involving cognitive functions and awareness, abnormal posture, neuralgia and neuritis (nerve pain), and contracture of hand (fixed tightening of muscle, tendons, or ligaments that prevents normal movement of the affected body part). R1's quarterly MDS dated 5/4/20, indicated R1 had moderately impaired 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, 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 hours. R1's care plan reviewed 7/27/20, indicated R1 was incontinent of bowel and directed staff to provide incontinent care after each incontinent bowel movement. R1's care plan lacked directives for frequency of checking and	2 910		

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2 910	Continued From page 21 changing. R1's Kardex/care guide provided 7/28/20, indicated R1 had a urinary catheter, required assistance of 2 staff for perineal care and was to be assessed for elimination needs or checked for incontinence every 2 hours. On 7/28/20, from 3:55 p.m. to 6:43 pm. during continuous observations, R1 had not been checked for incontinence or changed. At 6:43 p.m. NA-I and NA-E were starting to undress and wash up R1 before transferring R1 to bed from the wheelchair. After R1 was transferred to bed, NA-E washed bowel movement from R1's rectal area and buttocks. R1 had no indication of skin breakdown on his buttocks. On 7/28/20, at 7:07 p.m. NA-E verified R1 had not been repositioned or checked and changed since she started her shift at 2:30 p.m. NA-E stated R1 was already up when she started, and usually was in bed, so when she would get him up, he would be repositioned and changed at that time. Since R1 was already up, he did not get repositioned or changed. NA-E stated R1 should be repositioned and checked or changed every 2 hours, and verified R1 did not get repositioned or checked in 2 hours on this date. On 7/29/20, at 9:55 p.m. NA-A stated R1 required total assistance with cares, including toileting and repositioning. On 7/29/20, at 1:13 p.m. RN-A verified R1 was to be checked and changed every 2 hours, and was at risk for skin breakdown. RN-A verified R1's Kardex directed to check and change every 2 hours.	2 910		

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2 910	Continued From page 22 On 7/20/20, at 4:00 p.m. the director of nursing (DON) stated there should have been communication with shift change as to when R1 got out of bed so staff could reposition and check for incontinence timely. The DON verified R1 was at risk for skin breakdown. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise policies and procedures related to ensuring appropriate care and services related to incontinence. The director of nursing, or designee, could develop a system to educate staff and develop a monitoring system to ensure staff are providing this care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene during personal cares to prevent cross contamination for 1 of 2 residents (R1) observed during incontinent cares. Findings include: R1's Admission Record printed 7/30/20, indicated	21375	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	8/31/20

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21375	Continued From page 23 R2's diagnoses included hemiplegia and hemiparesis following cerebral infarction (weakness or paralysis on one side of body following a stroke), signs and symptoms involving cognitive functions and awareness, abnormal posture, neuralgia and neuritis (nerve pain), and contracture of hand (fixed tightening of muscle, tendons, or ligaments that prevents normal movement of the affected body part). R1's quarterly Minimum Data Set (MDS) dated 5/4/20, indicated R1 had moderately impaired 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, 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 hours. R1's care plan reviewed 7/27/20, indicated R1 was incontinent of bowel, and directed staff to provide incontinent care after each incontinent bowel movement. R1's care plan lacked directives for frequency of checking and changing. R1's Kardex/care guide provided 7/28/20, indicated R1 had a urinary catheter, required assistance of 2 staff for perineal care and was to be assessed for elimination needs or checked for incontinence every 2 hours. On 7/28/20, at 6:43 p.m. nursing assistant (NA)-I and NA-E were starting to undress and wash up	21375	hygiene, including hand hygiene while performing peri care. All NARs were educated on peri care and handwashing verbally, and via a video on peri care. All other staff will be educated on hand hygiene by 9/1/2020. Date of Compliance: 8/31/2020. Recurrence will be prevented by: In order to ensure the deficient practice does not happen again, the DON or designee, will conduct hand hygiene audits, including NARS, performing handwashing while performing peri care, on staff member from all shifts, every day, for one week, weekly for 8 weeks, and monthly for 2 months, then bring to QA to review. Corrections will be monitored by: DON/ADON/Nurse Managers/Designee	

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R1 before transferring R1 to bed from the wheelchair. NA-E and NA-I had washed hands and donned gloves. After R1 was transferred to bed, NA-I lowered R1's incontinent brief, and NA-E washed and rinsed R1's perineal area, and R1 was turned to the left. NA-E washed bowel movement from R1's rectal area and lower buttocks. NA-E then opened and applied ointment to R1's buttocks and rectal area. NA-E removed the soiled gloves, and without performing hand hygiene positioned and put a clean incontinent brief on R1. NA-E and NA-I turned R1 to his back and slightly to the right to remove the hoyer canvas from under him. NA-E moved the canvas and placed it on R1's wheelchair. NA-E put pillow cases on a pillow, and put it under R1's calves. NA-E then put R1's call light within his reach, and raised R1's head of the bed. NA-E then washed her hands in R1's bathroom before exiting the room. NA-E had not performed hand hygiene after removing her soiled gloves following incontinent cares, and before touching clean items.

On 7/28/20, at 7:07 p.m. NA-E verified she had performed hand hygiene after removing gloves following perineal cares, and before touching clean items. NA-E stated she was not sure when to sanitize or wash her hands.

On 7/29/20, at 1:13 p.m. registered nurse (RN)-A stated the expectation was for hand hygiene to be done before cares, after perineal cares, and going from dirty to clean tasks. RN-A stated staff should remove gloves and sanitize, and reglove going from dirty to clean tasks.

On 7/20/20, at 4:00 p.m. the director of nursing (DON) stated staff should change gloves, and perform hand hygiene when going from soiled to

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21375	Continued From page 25 clean, before continuing another task. The facility policy Hand Hygiene dated 6/17, directed infection control begins with hand hygiene and would reduce the spread of 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 urinals, and after removing gloves. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise policies as needed, train staff on appropriate indications for hand washing, assure an infection control program is established, maintained and monitored to assure care is provided to residents in a safe manner and in a sanitary environment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		