

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email October 9, 2020

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

RE: CCN: 245283

Cycle Start Date: July 29, 2020

Dear Administrator:

On October 5, 2020, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 18, 2020

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

RE: CCN: 245283

Cycle Start Date: July 29, 2020

Dear Administrator:

On July 29, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag), i.e., the plan of correction should be directed to:

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

Fax: (218) 723-2359

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 29, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 29, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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

PRINTED: 09/16/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245283		B. WING			C 07/29/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1201 8TH STREET SOUTH VIRGINIA, MN 55792	CODE	, <u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD E APPROPI	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN		FO	000			
	was completed at y complaint investiga not to be in compliant.	29/29, an abbreviated survey vour facility to conduct a ution. Your facility was found ance with 42 CFR Part 483, ong Term Care Facilities.					
	substantiated: H52	blaints were found to be 283025C, H5238026C, 3028C, and H5283029C.					
	as your allegation of Department's acce enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 686 SS=D	on-site revisit of yo validate that substate regulations has been your verification.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with Prevent/Heal Pressure Ulcer 1)(i)(ii)	F 6	886			8/31/20
	resident, the facility (i) A resident receive professional stands pressure ulcers and ulcers unless the ir demonstrates that (ii) A resident with president	sure ulcers. orehensive assessment of a					
LABORATORY	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE			(X6) DATE

Electronically Signed 08/26/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 686	with professional st promote healing, promote healing, promote healing, promote with the promote of the promote	andards of practice, to revent infection and prevent veloping. NT is not met as evidenced tion, interview, and document ailed to ensure repositioning ressure according to the care elopment of pressure ulcers (R1) reviewed for cord printed 7/30/20, indicated luded hemiplegia and ng cerebral infarction ysis on one side of body signs and symptoms involving and awareness, abnormal and neuritis (nerve pain), and I (fixed tightening of muscle, nts that prevents normal ffected body part). mum Data Set (MDS) dated 1 had moderately impaired daily decision making, had no haviors, required extensive or bed mobility, total assist of ore, extensive assist of one res, and was always el. R1's MDS further indicated en ulcers, and had a pressure	F 686	F686 Treatment/Svcs to Prevent/Pressure Ulcer Immediate Corrective Action: Resident #1 s care plan, group s and Kardex was updated with individualized repositioning needs Corrective Action as it applies to a The Policy and Procedure for Skin Assessment and Wound Manage remains current. All licensed nurses and NARs will re-educated on the need to refer the sheets/Kardex for individualized repositioning programs by 8/31/20 All residents will be reviewed to enthat their repositioning needs are indicated on the CNA group sheet they are independent. Care plans Kardex s were updated as well. Date of Compliance: 8/31/2020. Recurrence will be prevented by: Audits of 5 residents repositioning will be conducted 3x/week x 4, 2x 4, and then weekly x 4 to assure the practice is still appropriate. The rewill be shared with the facility QAF committee for input on the need to increase, decrease or discontinue audits. Corrections will be monitored by: DON/ADON/Nurse Managers/Designation of the content of the provided by: DON/ADON/Nurse Managers/Designation of the prevented by:	heet, bthers: ment be to group 020. nsure ts unless and ng plans /week x his esults Pl	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245283	B. WING _		07	// 29/2020
	PROVIDER OR SUPPLIER FERVIEW PINES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF THE	OULD BE	(X5) COMPLETION DATE
F 686	breakdown) had be determination was skin breakdown. Rindicated R1 had the (partial thickness led dermis presenting a red pink wound been present as an intact blister) to the outside from resting on the interventions had been notes additionally in and repositioned expowed incontinence. R1's care plan reviewas at risk for skin mobility and bowel current pressure in R1's care plan furth incontinent of bower assistance of with placked directives for repositioning, and obreakdown. R1's Kardex/care gindicated R1 required mobility and tracelimination needs a group sheets lacked and off-loading R1. On 7/28/20, from 3 continuous observation of the significated in his wheel any time was appropriated was appropriated.	en completed, and made that R1 was at risk for 1's progress notes further aree Stage 2 pressure injuries as a shallow open ulcer with a d, without slough. May also tor open/ruptured serumfilled de of the left foot and ankle wheelchair footrest, and een initiated. R1's progress adicated R1 was to be turned very 2 hours, and checked for and changed every 2 hours. Ewed 7/27/20, indicated R1 breakdown related to impaired incontinence and had a jury to left outer foot and ankle. Her indicated R1 was and directed staff to provide perineal cares. R1's care plan or frequency of turning and off-loading to prevent skin uide provided 7/28/20, ed assistance of two staff for ansfers, and was to have assessed every 2 hours. R1's directives for repositioning	F 68	66		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 686	starting to undress transferring R1 to b R1 was transferred movement from R1 R1 had no indication buttocks. On 7/28/20, at 7:03 to be repositioned or resident asks more repositioning informs sheets. NA-I stated toilets everyone who dinner, and after different control of the stated R1 was alread usually was in bed, up, he was repositioned every not get repositioned every not get repositioned. On 7/29/20, at 9:55 total assistance with repositioned timely. In and was at risk for repositioned timely. In a stated R1 was to be and was at risk for repositioned timely. In a stated R1 was to be and was at risk for repositioned timely. In a stated R1 was to be and was at risk for repositioned timely. In a stated R1 was to be and was at risk for repositioned timely. In a stated R1 was to be and was at risk for repositioned timely. In a stated R1 was to be and was at risk for repositioned timely. In a stated R1 was to be and was at risk for repositioned timely. In a stated R1 was to be	and wash up R1 before hed from the wheelchair. After to bed, NA-E washed bowel 's rectal area and buttocks. In of skin breakdown on his p.m. NA-I stated everyone is every 2 hours, unless the frequently. NA-I stated the nation is not on the group she usually repositions and en she starts her shift, before nner. In p.m. NA-E verified R1 had ded or checked and changed er shift at 2:30 p.m. NA-E add up when she started, and so when she would get him oned at that time. Since R1 did not get repositioned or	F 6	86		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION S	(X3) DATE SURVEY COMPLETED
		245283	B. WING		C 07/29/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792	1 01723/2320
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	got out of bed so st The DON verified R breakdown. The DO repositioned in his of pressure, and did a was not complete of The facility policy S Management dated and care lists be up and care provided a physician orders.	n shift change as to when R1 aff could reposition him timely. It was at risk for skin ON stated R could be chair to re-distribute the cknowledge re-distribution ff-loading of pressure. kin Assessment and Wound 7/18, directed the care plan dated with new skin concerns, according to nursing or ecrease in ROM/Mobility	F 688		8/31/20
	resident who enters range of motion do range of motion unle condition demonstration of motion is unavoid §483.25(c)(2) A resident motion receives appropriate assistance to maint the maximum practice reduction in mobility This REQUIREMENTS.	acility must ensure that a the facility without limited es not experience reduction in ess the resident's clinical ates that a reduction in range		F688 Increase/Prevent Decrease ROM/Mobility	in

CLIVILI	13 I OIT MEDICAILE	A MEDICAID SERVICES				WID INC.	0930-0391
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	СОМІ	SURVEY PLETED
		245202	B. WING			(
		245283	D. WING			07/2	29/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1:	201 8TH STREET SOUTH		
THE WA	TERVIEW PINES LLC			v	IRGINIA, MN 55792		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD		COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	i	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
					DEFICIENCY)		
E 600	O#		_				
F 688			F 6	886			
		ams according to the care			Immediate Corrective Action:		
		for 4 of 4 residents (R1, R2,			Resident #1, #2, #4, and #6□s res		
	R4, and R6) review	ed for restorative programs.			programs were reviewed for contin	ued	
					appropriateness of program.	_	
	Findings include:				Corrective Action as it applies to ot		
	D4				The Policy and Procedure for Resi		
	R1	7/00/00 : 1: 1: 1			Mobility and Range of Motion rema	ins	
		cord printed 7/30/20, indicated			current.		
		luded hemiplegia and			All NARs will be re-educated on		
		ng cerebral infarction			completing restorative exercises, a		
		ysis on one side of body			as ensuring appropriate document	ation of	
		signs and symptoms involving			the exercises by 8/31/2020.		
		and awareness, abnormal			The restorative program of each re		
		and neuritis (nerve pain), and			will be reviewed monthly by a licen		
		I (fixed tightening of muscle,			nurse for continued monitoring of g		
		nts that prevents normal			participation, and possibility of alte	ation	
	movement of the at	nected body part).			of program. This meeting will be		
	D1's guerterly Minir	num Data Cat (MDC)			documented in medical record.		
		mum Data Set (MDS) 5/4/20, indicated R1 had			Date of Compliance: 8/31/2020.		
					Recurrence will be prevented by:		
		d cognitive skills for daily			Audits of 5 residents ☐ restorative programs will be conducted 3x/wee	sk v 1	
		ad no rejection of care			, , ,	,	
		no restorative programs for			2x/week x 4, and then weekly x 4 to		
		e assessment period. R1's			ensure programs are completed and documented. The results will be significant to the second s		
	assessment.	s not assessed on this					
	assessifierit.				with the facility QAPI committee for on the need to increase, decrease		
	R1's Restorative N	ursing Program/Wellness			discontinue the audits.	OI .	
		of care), initiated 6/2/14,			Corrections will be monitored by:		
		b have passive range of motion			DON/ADON/Nurse Managers/Desi	anee	
		of left upper extremity five			DON/ADON/Nuise Managers/Des	grice	
		on 10/17/14, left hand PROM					
	was changed to se						
	ac changed to so						
	R1's Restorative No	ursing Program/Wellness					
		ed 5/8/14, indicated R1 was to					
		oduction and adduction, hip					
		d gastro with stretch on the					
		e range of motion (AROM) heel					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245283	B. WING _		07	C // 29/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1201 8TH STREET SOUTH VIRGINIA, MN 55792		,
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F 688	slides and ankle put A review of R1's reindicated R1 was to left, replace splint a weekly, and monitor times weekly right addition, R1 was to bilateral lower extreto allow feet to be frestorative docume following: - From 5/11/20 to 5 completed 2 of 3 of 18/20 to 5/25/20 to 5/25/20 to 5/25/20 to 5/25/20 to 5/25/20 to 5/25/20 to 6/25/20 to	storative documentation of have PROM to all joints on after hand ROM three times or splint as needed, and five apper extremity PROM. In have three times weekly emity PROM/ assisted AROM lat on the pedals. R1's entation further indicated the have three times were opportunities. 17/20, R1's programs were opportunities. 17/20, R1's programs were opportunities. 17/20, R1's upper extremity extremity extremity and lower some completed 2 of 3. 18 week of 6/1/20 to 6/7/20, was extremities. 17/20, R1's programs were opportunities. 18 week of 6/1/20 to 6/7/20, was extremities. 18 sor lower extremities, programs were extremities 3 of 3. 19 sor lower extremities, programs of 3 opportunities. 19 sor lower extremities, programs of 3 opportunities. 19 sor lower extremities, programs of 3 opportunities. 10 sor lower extremities, programs of 3 opportunities. 11 sor lower extremities, programs of 3 opportunities. 12 sor lower extremities, programs of 3 opportunities. 13 sor lower extremities, programs of 3 opportunities. 14 sor lower extremities, programs of 3 opportunities, programs on upper ompleted 2 of 3 opportunities, mities, programs were	F 68			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		C (X3) DATE SURVEY			
		245283	B. WING				29/2020
	PROVIDER OR SUPPLIER			120	EET ADDRESS, CITY, STATE, ZIP CODE 1 8TH STREET SOUTH CGINIA, MN 55792	,	
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F 688	completed 1 of 3 of From 7/20/20 to 7 completed 2 of 3 of No refusals were A note written by reassistant (NA)-J incompleted 2 of 3 of No refusals were A note written by reassistant (NA)-J incompleted 2 of 3 of No refusals were A note written by reassistant (NA)-J incompleted 2 of 3 of No restored 2 of NA-J documented 3 of NA-J documented 4 of NA-J documented 3	poportunities. 7/26/20, R1's programs were poportunities documented. estorative aide/nursing dicated R1 did not refuse restorative programs well. blank boxes indicated R1 was approached for therapy or rative aide working that day. cord printed 7/29/20, indicated luded dementia with nce, muscle weakness, and tive deficit, required extensive dimobility, transfers and unit. R1's MDS further or restorative programs. ewed 7/22/20, directed nursing 2 two to three times daily as to walk with R2 and one to ir behind R2. If R2 refused e re-approached at a later time		888			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED C		
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 1201 8TH STREET SOUTH VIRGINIA, MN 55792	•		
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F 688	Restorative Service 12/14/18, indicated exercises three times A review of R2's reindicated R2 was to AROM, and exercise weekly. In addition exercises three timextremity exercises R2's restorative do following: From 5/11/20 to 5 completed 1 of 3 operative down of the service	es Plan of Care dated R1 was to have specific quad es weekly. storative documentation have bilateral upper extremity ses as written, three times R2 was to have quad es weekly, and bilateral lower as listed three times a week. cumentation indicated the /17/20, R2's programs were poortunities. /24/20, R2's programs were poortunities, R2 refused 2 of liked instead on the third day. //31/20, R2's ROM was poortunities, and R2 refused y. week of 6/1/20 to 6/7/20, was 4/20, R2's ROM was poortunities and R2 refused 2	F 6	,			
	-From 6/29/20 to 7/completed 1 of 3 of day and "NO" docu-From 7/6/20, to 7/documented refuse blank a third day.	5/20, R2's ROM was opportunities, with a refusal one mented the third day. 12/20, R2's programs were d on 2 of 3 opportunities and R2's Restorative Aide Notes 11/20, provided explanation of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 688	R2's refusals on the From 7/13/20 to 7 documentation was third day. 7/15 - From 7/20/20 to 7 completed 2 of 3 of through a third day. In addition, R2 had completed and docindicated R2 was to with a wheelchair plassist of 2. R2's Documentation Response History rindicated R2's ambambulation is also of both documents revealed R2 either ambulation and refused both times. On 7/28/20, at 5:00 observed to offer a refused both times. On 7/28/20, at 7:02 walk in the corridor to her care plan. On 7/29/20, at 9:47 restorative aide whithe nursing assistal programs. On 7/29/20, at 9:55	bese dates. //19/20, R2's program blank 2 of 3 days and zeros a //26/20, R2's ROM was portunities and a line drawn //20, 7/25 an ambulation program to be umented by nursing, which ambulate three times daily ulled behind for safety and n on the Plan of Care report for the month of July, ulation is recorded. R2's recorded in Tasks. A review for the month of July/2020, ambulated or was offered used less than 3 times daily 5 p.m. two different staff were mbulation with R2, who p.m. R2 was observed to with two staff assist according a.m. NA-B stated the or did restorative programs and ants did not do restorative	F 68	38		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	CON	(X3) DATE SURVEY COMPLETED	
		245283	B. WING _			C / 29/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 688	stated R1 did not alleft leg, and she repstated R1 does RO right leg fine, and is stated when clients another sheet. On 7/29/20, at 11:4 (DON) stated the reto work on the unit, have a restorative abeen in transition w DON stated if a res restorative program another day. On 7/29/20, at 1:13 stated the nursing a ambulation if the reworking that day. Fpassive ROM. RN-ROM of his left low ulcers. RN-A verifie for the nursing assishe probably had no restorative aides would have a potent on 7/29/20, at 2:50 have restorative methem. The DON states and any charstiffness or a declinorders. The DON states and any charstiffness or a declinorders. The DON states and stiffness or a declinorders. The DON states and states and any charstiffness or a declinorders. The DON states and stiffness or a declinorders. The DON states and states an	de a.m. restorative aide/NA-C flow them to do ROM of the corted that to nursing. NA-C M programs on hands and a usually compliant. NA-C refuse, they document on 2 a.m. the director of nursing estorative aide is never pulled but sometimes they do not aide. The DON stated they had with new restorative aides. The ident misses a day of as, it should be made up p.m. registered nurse (RN)-A assistants would do ROM, or storative aides were not RN-A stated they would do the A verified R1 was not allowing are extremity due to pressure d R1 did not have a signs off stants to do ROM, so stated t gotten ROM when the are not there, and therefore atial for a decline in ROM. p.m. the DON stated they settings, but do not document atted they discussed residents' anges, such as increased e, and then would get therapy tated there were no notes on dicate there was a change in	F 68	8		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245283	B. WING _		07	// 29/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
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F 688	On 7/29/20, at 3:22 when a resident ha because it pops up they document "not On 7/29/20, at 4:08 have tried different restorative and for documentation tool so many different w makes it more diffic track. The DON sta	age 11 In p.m. NA-K stated they know as a restorative program on the computer. NA-K stated applicable" if it was not done. In p.m. the DON stated they ways of documenting R2, the family has a for ambulation, also. Having ways and places to document cult for staff and difficult to sted restorative programs esident's care plans.	F 68	38		
	R4's diagnoses inc behavioral disturbated R4's annual MDS of severely impaired of identified R4 did not care during the seven R4's care plan dates unable to ambulate and muscle weaking R4 was to ambulated R4's Therapy Company Restorative Serviced directed restorative performed.	munication to Wellness / es document dated 12/21/26, ambulation was to be				
	indicated R4 was to	torative documentation to be ambulated six times ative documentation further				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245283	B. WING _		07	C / 29/2020	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792			,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 688	indicated - From 5/11/20 to 5 of six opportunities - From 5/25/20 to 5 four of six opportunities - From 7/13/20 to 7 of six opportunities - From 7/20/20 to 7 of six opportunities - From 7/20/20 to 7 of six opportunities - No refusals were R6 R6's Admission Re R6's diagnoses inc abnormal posture. R6's annual MDS of BIMS score was 14 cognition. R6's MD not rejected care. R6's Restorative So 6/24/19, indicated R stretches to her har contractures. The performed three tim Review of R6's resi indicated R6 was to her lower extremitie restorative docume - From 5/11/20 to 5 performed one of th - From 6/29/20 to 7 performed one of th - From 6/29/20 to 7 performed one of the	/17/20, R4 was ambulated two idities. //19/20, R4 was ambulated two idities. //19/20, R4 was ambulated two idities. //26/20, R4 was ambulated five idicated. //26/20, R4 was ambulated five idicated five idicated osteoporosis and idiated 6/26/20, identified R6's which indicated intact idicated idicate	F 68	8			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245283	B. WING _		07	C // 29/2020	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792			,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 688	not performed No refusals were On 7/29/20, at 11:4 documentation was assistant (NA)-C. I documentation exis refused ambulation didn't get walked." restorative aides rebelieved no one pewhen restorative ai On 7/29/20, at 12:0 conducted with the nursing staff walked aides were not schwere placed at each which residents nestated NAs' were not stretching as they was the DON stated rescheduled daily, how which no one was so DON stated staff do progress notes. The note existed it was care. On 7/29/20, at 12:2 conducted with RN performed restorational aides were not avait staff performed ger residents. RN-B st when residents were	documented. 5 a.m., R4's restorative reviewed with nursing	F 68	8			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245283	B. WING _		07	/29/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 688	restorative aides restarted. On 7/29/20, at 3:08 conducted with NA was at the nurses' restorative cares not document was reviconfirmed the restorative confirmed the restorative document was reviconfirmed the restorative has a manager placed a indicated with resprograms. NA-H suprogram and she used to the restorative aides' document was getting restorative aides' document with the facility restorative pin-progress. The Expression of the restorative pin-progress.	signed when COVID-19 sp.m. an interview was F. NA-F stated a document station which indicated what seeded to be completed. The ewed, with NA-F and NA-F prative sheet lacked indication alked. sp.m. an interview was F. NA-H stated the unit list at the nurses' station which idents were on restorative tated R4 was on a walking sually ambulated five to 15 ked how nursing staff was restorative cares were not stated staff assumed R4's gidone. NA-H stated the ocumentation was locked in	F 68	38		
	conducted with the were expected to for treatment plans. To check the record to plan included. The	p.m. an interview was DON. The DON stated staff bllow resident restorative he DON stated she needed to see what R6's restorative DON stated she did not know a restorative cares, but had nes a lot.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG	` ′	E SURVEY IPLETED
		245283	B. WING		C 07/29/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 688	Motion dated 7/17, limited range of mo services to increase decrease in ROM." "Residents with lim appropriate service to maintain or improin mobility is unavo Bowel/Bladder Inco CFR(s): 483.25(e) (1) S483.25(e) (1) The first service of the service to maintain or improin mobility is unavously and service of the service o	dent Mobility and Range of directed, "Residents with tion will receive treatment and e and/or prevent a further. The policy further directed, ited mobility will receive s, equipment and assistance ove mobility unless reduction idable." ntinence, Catheter, UTI 1)-(3)	F 6			8/31/20
	admission receives maintain continence condition is or becondition in the becondition is or becondition in the becondition in the becondition is or becondition in the becondition in the becondition is or becondition in the becondition i	services and assistance to e unless his or her clinical mes such that continence is ntain. resident with urinary d on the resident's ressment, the facility must restrict the facility without an is not catheterized unless the condition demonstrates that				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	COM	MPLETED
		245283	B. WING			C / 29/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
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F 690	continence to the e §483.25(e)(3) For a incontinence, based comprehensive assensure that a reside receives appropriat restore as much no possible. This REQUIREMEN by: Based on observat review, the facility fi incontinence cares residents (R4, R1) bladder incontinence Findings include: R4's Admission Re R4's diagnoses include behavioral disturbat weakness. R4's annual Minimu 5/5/20, identified Ra cognition. R4's MD required extensive ostomy, and was al R4's Urinary Incont Catheter Care Area 5/8/20, indicated Ra and her elimination every two hours. R4's Kardex dated incontinent of bladd	extent possible. It resident with fecal don the resident's resessment, the facility must rent who is incontinent of bowel the treatment and services to remail bowel function as the service of the serv	F6	F690 Bowel/Bladder Incontinent Catheter, UTI Immediate Corrective Action: Resident #1 and #4 skin was chensure that they did not have an breakdown as a result of not recincontinent cares per their scheon NAR-E, NAR-G, and NAR-I were educated on need to complete retoileting cares per NAR care sheon Corrective Action as it applies to the Policy and Procedure for Action Daily Living remains current. All NARs will be re-educated on completing resident toileting care NAR care sheet by 8/31/2020. All residents will be reviewed to that their toileting needs are on the care sheets. Date of Compliance: 8/31/2020. Recurrence will be prevented by Audits of 5 residents will be conducted as a completed timely. The will be shared with the facility QA committee for input on the need increase, decrease or discontinu	ecked to y skin eiving dule. e esident eet. others: ctivities of es per ensure to he NAR ducted nen oileting e results API to	

		` IDENTIFICATION NUMBED: ` `		LE CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED C	
		245283	B. WING		1	/ 29/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 690	and check for incorduring the day and Kardex further direct ostomy every two homogeneous of the costomy every two homogeneous homogeneous of the costomy every two homogeneous homogeneous homogeneous homogeneous of the costomy every two homogeneous	ntinence, every two hours rounds during the night. The cted staff to check R4's nours. p.m. R4 was observed in her seated in a wheelchair. R4 tand, near her bed, and was n her left hand. p.m. R4's call light was Nursing assistant (NA)-G within the minute, and closed ited the R4's room at 3:58 p.m. open and she was observed nair, and was facing a	F 690	audits. Corrections will be monitored b DON/ADON/Nurse Managers/I			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245283	B. WING		0:	C 7/ 29/2020	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792			1 01/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 690	On 7/28/20, at 7:06 conducted with NA-usually incontinent, resident much. NA R4 was on a check stated in general, re and changed every had an ostomy, and two hours. NA-F st R4's ostomy was la On 7/28/20, at apprinterview was cond R4 required stand transferred or toilet continent "sometim ostomy and it need hours. NA-G stated checked-and-chang stated she emptied this time, R4's ostomy NA-G. R4's ostomy NA-G stated it need from ostomy pouch from the ostomy poostomy pouch was with light brown sto incontinence produ would "normally" chincontinence produ clean the shower rowas waiting to use room. NA-G stated R4's ostomy pouch	p.m. an interview was -F. NA-F stated R4 was not but she didn't work with the -F stated she was unsure if and change schedule. NA-F esidents were to be checked two hours. NA-F stated R4 d staff were to check it every rated she was unsure when st checked. Toximately 7:30 p.m. an ructed with NA-G. NA-G stated by assistance when she was ed. NA-G stated R4 was es." NA-G stated R4 had an red to be emptied every two d R4 also needed to be ged every two hours. NA-G R4's ostomy at 6:30 p.m. At my pouch was filled with air and ded to be "burped" (release air). NA-G then released the air ruch. NA-G confirmed R4's approximately one-half full ol. NA-G also confirmed R4's ct was "wet." NA-G stated she range a resident's ot, however, she needed to com because another resident it. NA-G then exited R4's I she did not document when		90			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C	
		245283	B. WING _		07	// 29/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
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F 690	an ostomy. RN-B s check-and-change the day, and round stated you wound r pouch to be one-har RN-B stated staff wresident's incontine to be wet. RN-B st skin breakdown or infection if an incording the day of the conducted with the The DON stated Rahad an ostomy which The DON stated stand change R4 evestated she would his shower and care for incontinence production. Supporting "Appropriate care a for residents who a independently, with	stated staff were expected to R4 every two hours, during so during night shift. RN-B not normally expect an ostomy alf full of stool in an hour. Yould be expected to change a ence product if it was identified ated a resident could have develop a urinary tract titinence product was not	F 69			
	R2's diagnoses inc hemiparesis followi (weakness or paral following a stroke), cognitive functions	cord printed 7/30/20, indicated luded hemiplegia and ng cerebral infarction ysis on one side of body signs and symptoms involving and awareness, abnormal and neuritis (nerve pain), and				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C		
		245283	B. WING _		07	// 29/2020	
	PROVIDER OR SUPPLIER TERVIEW PINES LLC			STREET ADDRESS, CITY, STATE, ZIP COE 1201 8TH STREET SOUTH VIRGINIA, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 690	contracture of hand tendons, or ligamen movement of the at R1's quarterly MDS had moderately implecision making, he behaviors, required for bed mobility, tot extensive assist of was always incontinurinary catheter. R1's quarterly reviet 7/27/20, indicated F wore an incontinent for bowel incontinent for bowel incontinent bowel movement. directives for frequenchanging. R1's Kardex/care gindicated R1 had a assistance of 2 state be assessed for eli incontinence every On 7/28/20, from 3 continuous observations observations of the wheelchair. After the wheelchair.	I (fixed tightening of muscle, nts that prevents normal fected body part). I dated 5/4/20, indicated R1 paired cognitive skills for daily ad no rejection of care extensive assist of two staff al assist of two for transfers, one staff for toileting cares, nent of bowel, and had a expressive progress notes dated R1 was incontinent of bowel, to brief and was to be checked note and changed every 2 Evwed 7/27/20, indicated R1 powel and directed staff to care after each incontinent R1's care plan lacked ency of checking and uide provided 7/28/20, urinary catheter, required ff for perineal care and was to mination needs or checked for	F 69	90			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY IPLETED
		245283	B. WING			C 07/29/2020	
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>		FREET ADDRESS, CITY, STATE, ZIP CODE	0112	29/2020
THE WAT	ERVIEW PINES LLC				201 8TH STREET SOUTH		
				VI	IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	On 7/28/20, at 7:07 not been reposition since she started histated R1 was alreausually was in bed, up, he would be reptime. Since R1 was repositioned or chabe repositioned and hours, and verified checked in 2 hours On 7/29/20, at 9:55 total assistance wit repositioning.	R1 had no indication of skin puttocks. 7 p.m. NA-E verified R1 had ed or checked and changed er shift at 2:30 p.m. NA-E ady up when she started, and so when she would get him positioned and changed at that is already up, he did not get anged. NA-E stated R1 should dichecked or changed every 2 R1 did not get repositioned or on this date. 5 p.m. NA-A stated R1 required h cares, including toileting and	F6	90			
	be checked and ch at risk for skin brea Kardex directed to hours. On 7/20/20, at 4:00	p.m. RN-A verified R1 was to anged every 2 hours, and was kdown. RN-A verified R1's check and change every 2					
F 880 SS=D	got out of bed so st for incontinence tim at risk for skin brea Infection Prevention	n shift change as to when R1 aff could reposition and check nely. The DON verified R1 was kdown. n & Control	F 8	80			8/31/20
	infection prevention	Control stablish and maintain an n and control program e a safe, sanitary and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1201 8TH STREET SOUTH VIRGINIA, MN 55792		20,2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	development and tr diseases and infect \$483.80(a) Infection program. The facility must es and control program a minimum, the followed staff, volunteers, visproviding services to arrangement based conducted accordinaccepted national services for the but are not limited to (i) A system of surver possible communication infections before the persons in the facili (ii) When and to who communicable diserported; (iii) Standard and tr to be followed to profit (iv) When and how it resident; including to (A) The type and do to profit (iii) When and how it resident; including to (A) The type and do to profit (iii) When and how it resident; including to (A) The type and do to profit (III) when and how it resident; including to (A) The type and do to (III) when and how it resident; including the control of the type and do to (III) when and how it resident; including the control of the type and do (III) when and the type and type and the type and	mment and to help prevent the ansmission of communicable ions. In prevention and control tablish an infection prevention in (IPCP) that must include, at owing elements: Item for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual lupon the facility assessment in g to §483.70(e) and following tandards; en standards, policies, and program, which must include, one eillance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a	F8	,		
		nat the isolation should be the sible for the resident under the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245283	B. WING		C 07/29/2020	
NAME OF F	PROVIDER OR SUPPLIE		1	STREET ADDRESS, CITY, STATE, ZIP CO		29/2020
	TERVIEW PINES LL			1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 880	must prohibit empdisease or infected contact with reside contact will transmoved in the corrective actions \$483.80(a)(4) As identified under the corrective actions \$483.80(e) Linens Personnel must hear transport linens of infection. \$483.80(f) Annual The facility will confect in the facility will confect in the facility will confect in the facility hygiene during personnel must be facility hygiene during personnel for during incontinent for the facility hygiene during personnel for the facility hygiene during incontinent for the facility hygiene during a stroke cognitive function posture, neuralgiant for the facility function fu	nces under which the facility ployees with a communicable d skin lesions from direct ents or their food, if direct nit the disease; and ene procedures to be followed in direct resident contact. System for recording incidents are facility's IPCP and the taken by the facility. Solution and the spread of as to prevent the spread of as to prevent the spread of their program, as necessary. ENT is not met as evidenced action, interview, and document a failed to ensure proper hand ersonal cares to prevent cross 1 of 2 residents (R1) observed	F8	F880 Infection Prevention 8 Immediate Corrective Action NA-E received education on process for sanitizing/washin Corrective Action as it applie All residents are at risk to po affected. Policies/Procedures/System The facility SQAPI committ a root cause analysis to ider problem(s) that resulted in th practice, and develop an inte corrective action plan to prevecurrence. The Policy and Procedure for Hygiene was reviewed by D6	at the proper ng her hands. es to others: otentially be a Changes tee conducted ntify the his deficient ervention and vent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245283	B. WING			C 29/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1201 8TH STREET SOUTH VIRGINIA, MN 55792	•	23/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	tendons, or ligamen movement of the an R1's quarterly Minit 5/4/20, indicated R cognitive skills for or rejection of care be assist of two staff for two for transfers, extoileting cares, was and had a urinary of R1's quarterly reviet 7/27/20, indicated R wore an incontinent for bowel incontinent for bowel incontinent bowel movement. directives for frequenchanging. R1's Kardex/care gindicated R1 had a assistance of 2 starbe assessed for eli incontinence every On 7/28/20, at 6:43 and NA-E were star R1 before transferr wheelchair. NA-E and donned gloves bed, NA-I lowered NA-E washed and	ints that prevents normal ffected body part). mum Data Set (MDS) dated 1 had moderately impaired daily decision making, had no chaviors, required extensive or bed mobility, total assist of extensive assist of one staff for a always incontinent of bowel, eatheter. Ew progress notes dated R1 was incontinent of bowel, to brief, and was to be checked ince and changed every 2 Ewed 7/27/20, indicated R1 bowel, and directed staff to care after each incontinent R1's care plan lacked ency of checking and Juide provided 7/28/20, urinary catheter, required ff for perineal care and was to mination needs or checked for	F 88	remains current. Training Education All NAR swere educated or hygiene while completing per 8/31/2020. All staff were educated on hat Hand hygiene education inclutest that measured competer 9/92020 Recurrence will be prevented The Director of Nursing, the Preventionist and other facilit will conduct audits on all shifts, every day week, then may decrease the based upon compliance. Audits should co 100% compliance is met. The Director of Nursing, Infe Preventionist or designee wil results of audits and monitor Quality Assurance Program I (QAPI) program. Corrections will be monitored DON/ADON/Nurse Manager	ri care, by and hygiene. uded a post ncy by d by: Infection ty leadership of for one e frequency continue until ction Il review the ing with the Improvement d by:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245283	B. WING				29/2020
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC				120	EET ADDRESS, CITY, STATE, ZIP CODE 1 8TH STREET SOUTH 1 GINIA, MN 55792	1 077	23/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	movement from R1 buttocks. NA-E ther to R1's buttocks and the soiled gloves, a hygiene positioned brief on R1. NA-E and slightly to the ricanvas from under and placed it on R1 cases on a pillow, a NA-E then put R1's raised R1's head of her hands in R1's broom. NA-E had no after removing her incontinent cares, a items.	ge 25 's rectal area and lower n opened and applied ointment d rectal area. NA-E removed nd without performing hand and put a clean incontinent and NA-I turned R1 to his back ght to remove the hoyer him. NA-E moved the canvas 's wheelchair. NA-E put pillow and put it under R1's calves. call light within his reach, and the bed. NA-E then washed athroom before exiting the ot performed hand hygiene soiled gloves following and before touching clean p.m. NA-E verified she had giene after removing gloves	F 8	80			
	following perineal c clean items. NA-E s to sanitize or wash On 7/29/20, at 1:13 stated the expectat	ares, and before touching stated she was not sure when					
	going from dirty to on should remove glow going from dirty to on 7/20/20, at 4:00	clean tasks. RN-A stated staff yes and sanitize, and reglove					
	perform hand hygie clean, before contir The facility policy H directed infection co	ne when going from soiled to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245283	B. WING_			C / 29/2020	
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			((EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 880	to perform hand hygassisting a resident	erms. The policy directed staff giene before and after with personal cares, toileting, or used linens, catheters and	F 84	80			
ı							



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 18, 2020

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

Re: State Nursing Home Licensing Orders

Event ID: UHW711

Dear Administrator:

The above facility was surveyed on July 28, 2020 through July 29, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

Teresa Ament, Unit Supervisor Email: teresa.ament@state.mn.us

Phone: (218) 302-6151 Fax: (218) 723-2359

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

PRINTED: 09/16/2020 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:		С		
		00582	B. WING			9/2020
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADI			STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO , MN 55792	UTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall with a schedule of f the Minnesota Depart					
	requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tag alle number indicated below. In the several items, failure to the items will be considered a Lack of compliance upon any item of multi-part rule will ament of a fine even if the item aring the initial inspection was				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	survey was comple complaint investiga to be NOT IN comp	rS: n 7/29/20, an abbreviated ted at your facility to conduct tions. Your facility was found bliance with 42 CFR Part 483, ong Term Care Facilities.				
	The following comp	laints were found to be				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 08/26/20

STATE FORM 6899 If continuation sheet 1 of 26 UHW711

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	A. BUILDING:					
		00582	B. WING		07/29/2	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WATERVIEW PINES LLC			STREET SO MN 55792	DUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
		H5283025C, H5238026C, 3028C, and H5283029C.				
		ed in ePOC and therefore a uired at the bottom of the first 567 form.				
2 890	MN Rule 4658.0529 Motion	5 Subp. 2 A Rehab - Range of	2 890			8/31/20
	that is directed towa through positioning implemented and n comprehensive res of nursing services	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without a limited rai experience reduction	ho enters the nursing home nge of motion does not on in range of motion unless al condition demonstrates range of motion is				
	by: Based on observatireview, the facility for restorative programs of R4, and R6) review Findings include: R1	ent is not met as evidenced ion, interview, and document ailed to ensure implementation ams according to the care for 4 of 4 residents (R1, R2, red for restorative programs.		F688 Increase/Prevent Decrease ROM/Mobility Immediate Corrective Action: Resident #1, #2, #4, and #6□s resprograms were reviewed for continappropriateness of program. Corrective Action as it applies to on The Policy and Procedure for Resident and Range of Motion remacurrent.	itorative nued thers: ident	

Minnesota Department of Health

STATE FORM 6899 UHW711 If continuation sheet 2 of 26

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE :	
			A. BUILDING:			
		00582	B. WING		07/2	; 9/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SC , MN 55792	DUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 890	R1's diagnoses inclaiment hemiparesis following a stroke), cognitive functions posture, neuralgia a contracture of hand tendons, or ligament movement of the affection making, has behaviors, and had 15 minutes over the range of motion was assessment. R1's Restorative Not Group POC (plan of indicated R1 was to (PROM) to all joint times weekly, and of was changed to see R1's Restorative Not Group POC, initiated have heel slides, as internal rotation and right, and left active slides and ankle put A review of R1's resindicated R1 was to left, replace splint a weekly, and monito times weekly right to addition, R1 was to addition, R1 was to addition, R1 was to an all follows.	duded hemiplegia and ng cerebral infarction ysis on one side of body signs and symptoms involving and awareness, abnormal and neuritis (nerve pain), and I (fixed tightening of muscle, nts that prevents normal fected body part). mum Data Set (MDS) 5/4/20, indicated R1 had d cognitive skills for daily ad no rejection of care no restorative programs for assessment period. R1's s not assessed on this ursing Program/Wellness of care), initiated 6/2/14, on have passive range of motion of left upper extremity five on 10/17/14, left hand PROM	2 890	All NARs will be re-educated on completing restorative exercises, as ensuring appropriate document the exercises by 8/31/2020. The restorative program of each rewill be reviewed monthly by a licenturse for continued monitoring of participation, and possibility of alterogram. This meeting will be docin medical record. Date of Compliance: 8/31/2020. Recurrence will be prevented by: Audits of 5 residents restorative programs will be conducted 3x/we 2x/week x 4, and then weekly x 4 ensure programs are completed adocumented. The results will be swith the facility QAPI committee for the need to increase, decrease discontinue the audits. Corrections will be monitored by: DON/ADON/Nurse Managers/Design of the complete of the compl	resident nsed goals, eration of cumented eek x 4, to and shared or input e or	

Minnesota Department of Health

STATE FORM 6899 UHW711 If continuation sheet 3 of 26

Minnesota Department of Health		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	COMP	PLETED
		2
00582 B. WING		29/2020
00302	0112	19/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WATERWEN PINES I I C		
THE WATERVIEW PINES LLC VIRGINIA, MN 55792		
	ORRECTION	(X5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF C PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIO		COMPLETE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO TH		DATE
DEFICIENCY)	
2 890 Continued From page 3 2 890		
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.		
- INO IGIUSAIS WEIE UOCUITICITICU.		
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		

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		SURVEY PLETED
	00582	B. WING		l l	C 29/2020
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC	1201 8TH	DRESS, CITY, ST			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
R2's Admission Re R2's diagnoses incomplete behavioral disturbate difficulty in walking. R2's quarterly MDS had a severe cognitassistance with been ambulation on the mindicated R1 had not recomplete a severe cognitassistance with been ambulation on the mindicated R1 had not recomplete a severe cognitassistance with been ambulated R1 had not recomplete a severe plan reviews taff to ambulate R able, with one staff push the wheelchate twice, R2 was to be up to three times do the severe severe indicated F following: AROM/P hand exercises three findicated R2 was to lower extremities the Restorative Services 12/14/18, indicated exercises three times A review of R2's resindicated R2 was to AROM, and exercise weekly. In addition exercises three times extremity exercises services and the service of R2's resindicated R2 was to AROM, and exercise weekly. In addition exercises three times extremity exercises services and the services and the services and the services and the services are services and the services and the services are services and the services and the services and the services are services are services and the services are services and the services are services and the services are s	cord printed 7/29/20, indicated luded dementia with ince, muscle weakness, and divided deficit, required extensive districtive deficit, required extensive districtive programs. Example 1/22/20, directed nursing 2 two to three times daily as to walk with R2 and one to irr behind R2. If R2 refused the re-approached at a later time aily. Exercises Plan of Care dated R2 was to have 3 of the ROM, upper extremity and the etimes weekly. Another the Plan of Care dated 3/22/11, to have other exercises on the Plan of Care dated R2 was to have specific quader R1 was to have specific quader R	2 890			

Minnesota Department of Health

STATE FORM 6899 UHW711 If continuation sheet 5 of 26

Millinesc	ita Department of He	aitti				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					(
		00582	B. WING			9/2020
		00362			0712	9/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1201 8TH	STREET SO	UTH		
THE WA	TERVIEW PINES LLC		MN 55792			
	OUR MAA DV OTA			DROVIDEDIO DI ANI OF CORDECTIO	~~	
(X4) ID PREFIX		TEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
2 000	O	F	2 200			
2 890	Continued From pa	ge 5	2 890			
	following:					
		/17/20, R2's programs were				
	completed 1 of 3 or					
		24/20, R2's programs were				
		pportunities, R2 refused 2 of				
		lked instead on the third day.				
		/31/20, R2's ROM was				
		pportunities, and R2 refused				
	the third opportunity					
		week of 6/1/20 to 6/7/20, was				
	not provided.					
		4/20, R2's ROM was				
		pportunities and R2 refused 2				
	days after 3-4 appre					
		21/20, R2's ROM programs				
		3 opportunities, and R2				
		re-approaches documented				
	one day.	то арргоастое ассатот				
		28/20, R2's ROM was				
		pportunities, and R2 refused				
	two other days.	,				
		5/20, R2's ROM was				
		pportunities, with a refusal one				
		mented the third day.				
	•	I2/20, R2's programs were				
	documented refuse	d on 2 of 3 opportunities and				
		R2's Restorative Aide Notes				
		11/20, provided explanation of				
	R2's refusals on the					
	- From 7/13/20 to 7	/19/20, R2's program				
		blank 2 of 3 days and zeros a				
	third day. 7/15	•				
		/26/20, R2's ROM was				
		pportunities and a line drawn				
	through a third day.					
	,					
	In addition, R2 had	an ambulation program to be				
		umented by nursing, which				
		ambulate three times daily				
		ulled behind for safety and				

Minnesota Department of Health

STATE FORM 6899 UHW711 If continuation sheet 6 of 26

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. BOILBING.			
		00582	B. WING			9/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO , MN 55792	UTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 890	Continued From pa	ge 6	2 890			
	assist of 2.					
	Response History r indicated R2's amb ambulation is also of of both documents revealed R2 either	n on the Plan of Care eport for the month of July, ulation is recorded. R2's recorded in Tasks. A review for the month of July/2020, ambulated or was offered used less than 3 times daily 5				
		p.m. two different staff were mbulation with R2, who				
		p.m. R2 was observed to with two staff assist according				
	restorative aide who	a.m. NA-B stated the o did restorative programs and nts did not do restorative				
		a.m. NA-A stated the programs and the m.				
	stated R1 did not a left leg, and she rep stated R1 does RO right leg fine, and is	4 a.m. restorative aide/NA-C llow them to do ROM of the ported that to nursing. NA-C M programs on hands and susually compliant. NA-C refuse, they document on				
	(DON) stated the reto work on the unit,	2 a.m. the director of nursing estorative aide is never pulled but sometimes they do not aide. The DON stated they had				

Minnesota Department of Health

STATE FORM 6899 UHW711 If continuation sheet 7 of 26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00582	B. WING		07/2	9/2020
	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 890	Continued From pa	ge 7	2 890			
	DON stated if a res	ith new restorative aides. The ident misses a day of s, it should be made up				
	stated the nursing a ambulation if the reworking that day. For passive ROM. RN-ROM of his left lower ulcers. RN-A verifie for the nursing assist he probably had not restorative aides we	p.m. registered nurse (RN)-A assistants would do ROM, or storative aides were not RN-A stated they would do the A verified R1 was not allowing er extremity due to pressure d R1 did not have a signs off stants to do ROM, so stated t gotten ROM when the ere not there, and therefore tial for a decline in ROM.				
	have restorative me them. The DON sta status and any char stiffness or a declin orders. The DON st	p.m. the DON stated they betings, but do not document ted they discussed residents' nges, such as increased e, and then would get therapy tated there were no notes on dicate there was a change in				
	when a resident has because it pops up	p.m. NA-K stated they know s a restorative program on the computer. NA-K stated applicable" if it was not done.				
	have tried different restorative and for f documentation tool so many different w makes it more diffic	for ambulation, also. Having yays and places to document bult for staff and difficult to ted restorative programs				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			,
		00582	B. WING		I	9/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO MN 55792	DUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 890	Continued From pa	nge 8	2 890			
	R4					
	R4's diagnoses inc	cord dated 7/29/20, indicated luded dementia without nce and muscle weakness.				
	severely impaired of identified R4 did no	lated 5/5/20, identified R4' had cognition. The MDS further of walk, and had not rejected of yen day look-back period				
	unable to ambulate	ed 8/12/19 indicated R4 was e safely due to osteoarthritis ess. The care plan directed e (walk).				
	Restorative Service	munication to Wellness / es document dated 12/21/26, e ambulation was to be				
	indicated R4 was to weekly. The restor indicated - From 5/11/20 to 5 of six opportunities					
	four of six opportur - From 7/13/20 to 7 of six opportunities	7/19/20, R4 was ambulated two 7/26/20, R4 was ambulated five				
	R6					
		cord dated 7/29/20, indicated luded osteoporosis and				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			71. 501251110.			
		00582	B. WING			9/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO , MN 55792	DUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 890	Continued From pa	ge 9	2 890			
	BIMS score was 14 cognition. R6's MD not rejected care. R6's Restorative S6 6/24/19, indicated F stretches to her har contractures. The sperformed three times restorative docume - From 5/11/20 to 5 performed one of the From 5/25/20 to 5 performed two of the From 6/29/20 to 7 performed one of the stretches to her lower extremition restorative docume - From 5/11/20 to 5 performed one of the From 6/29/20 to 7 performed one of the stretches was 14 countries.	torative documentation to have stretching performed to es three times weekly. The entation further indicated: /17/20, R6's stretching was have opportunities. /31/20, R6's stretching was have opportunities. /5/20, R6's stretching was have opportunities. /19/20, R6's stretching was have opportunities.				
	On 7/29/20, at 11:4 documentation was assistant (NA)-C. I documentation exis refused ambulation didn't get walked." restorative aides rebelieved no one pe	5 a.m., R4's restorative reviewed with nursing				
	conducted with the nursing staff walked	8 p.m. an interview was DON. The DON stated tresidents when restorative eduled. The DON stated lists				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			,
		00582	B. WING			9/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO MN 55792	UTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 890	which residents new stated NAs' were not stretching as they will have been been been been stated NAs' were not stretching as they will have been been been been stated allow the no one was a DON stated staff do progress notes. The note existed it was care. On 7/29/20, at 12:2 conducted with RN performed restorational aides were not avain staff performed ger residents. RN-B stated when residents were not avain staff performed ger residents. RN-B stated when residents were not avain staff performed ger residents. RN-B stated when residents were not avain staff performed ger residents. RN-B stated. On 7/29/20, at 1:07 conducted with the restorative aides restorative aides restorative cares not document was revisited. On 7/29/20, at 3:08 conducted with NA-was at the nurses's restorative cares not document was revisited. On 7/29/20, at 3:08 conducted with NA-was at the nurses's restorative cares not document was revisited. On 7/29/20, at 3:08 conducted with NA-was at the nurses's restorative cares not document was revisited. On 7/29/20, at 3:08 conducted with NA-was at the nurses's restorative cares not document was revisited. On 7/29/20, at 3:08 conducted with NA-was at the nurses's restorative cares not document was revisited.	h nurses' station so staff knew eded to get walked. The DON of allowed to perform were not trained by therapy. Storative aides were wever, there may be a day in scheduled due to training. The ocumented refusals on therapy in DON stated if no progress likely a resident did not refuse. 6 p.m. an interview was allowed. RN-B stated nursing staff we cares when restorative elable. RN-B stated nursing of the stretching and walked ated nursing staff documented are walked, but not stretched. p.m. an interview was DON. The DON stated two signed when COVID-19 p.m. an interview was and interview was are station which indicated what seeded to be completed. The ewed, with NA-F and NA-F arative sheet lacked indication	2 890			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00582	B. WING			C 29/2020
	PROVIDER OR SUPPLIER TERVIEW PINES LLC	1201 8TH	DRESS, CITY, S STREET SO , MN 55792	STATE, ZIP CODE UTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 890	made aware when a completed. NA-H is walking was getting restorative aides' do the restorative office. On 7/29/20, at 3:32 conducted with the facility restorative p in-progress. The Doversight of the prohand off. On 7/29/20, at 3:53 conducted with the were expected to for treatment plans. The check the record to plan included. The if R4 and R6 refuse not heard their name are lated to increase decrease in ROM." "Residents with limit appropriate services to increase decrease in ROM." "Residents with limit appropriate services to maintain or improfin mobility is unavoid suggested to the facility DON, or designee, nursing staff related procedures. The question of the suggested in the procedures. The question of the procedures. The question of the procedures.	restorative cares were not stated staff assumed R4's done. NA-H stated the ocumentation was locked in afterhours. p.m. an interview was DON. The DON stated the rogram was a work ON stated she recently started gram and there wasn't a good p.m. an interview was DON. The DON stated staff ollow resident restorative he DON stated she needed to see what R6's restorative DON stated she did not know at restorative cares, but had les a lot. Ident Mobility and Range of directed, "Residents with tion will receive treatment and and/or prevent a further The policy further directed, ited mobility will receive s, equipment and assistance over mobility unless reduction idable." THOD OF CORRECTION: Sing, or designee, could ment policies and procedures y restorative program. The could provide training for all	2 890			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			,
		00582	B. WING			9/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO , MN 55792	DUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 890	Continued From pa	ge 12	2 890			
	audits to ensure co	mpliance.				
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					
2 900	0 MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers		2 900			8/31/20
	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:					
	without pressure s pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessar	ho has pressure sores y treatment and services to event infection, and prevent yeloping.				
	by: Based on observation review, the facility for and off-loading of pullipping plan to prevent device for 1 of 3 residents repositioning. Findings include: R1's Admission Residents	ent is not met as evidenced on, interview, and document ailed to ensure repositioning ressure according to the care elopment of pressure ulcers (R1) reviewed for		F686 Treatment/Svcs to Prevent/H Pressure Ulcer Immediate Corrective Action: Resident #1 s care plan, group st and Kardex was updated with individualized repositioning needs Corrective Action as it applies to o The Policy and Procedure for Skir Assessment and Wound Manager remains current. All licensed nurses and NARs will	heet, .thers: n ment	

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPI	
					c	
		00582	B. WING			, 9/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AN	DESS CITY S	STATE, ZIP CODE		
NAIVIL OI I	-NOVIDEN ON SUFFEIEN		STREET SO	,		
THE WA	TERVIEW PINES LLC		MN 55792			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION)NI	(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 13	2 900			
		ng cerebral infarction		re-educated on the need to refer t	o group	
		ysis on one side of body		sheets/Kardex for individualized		
		signs and symptoms involving		repositioning programs by 8/31/20		
		and awareness, abnormal and neuritis (nerve pain), and		All residents will be reviewed to en		
		I (fixed tightening of muscle,		that their repositioning needs are in on the CNA group sheets unless t		
		nts that prevents normal		independent. Care plans and Karo		
	movement of the af			were updated as well.		
		,		Date of Compliance: 8/31/2020.		
		num Data Set (MDS) dated		Recurrence will be prevented by:		
	•	1 had moderately impaired		Audits of 5 residents repositionir		
		laily decision making, had no haviors, required extensive		will be conducted 3x/week x 4, 2x, 4, and then weekly x 4 to assure the		
		or bed mobility, total assist of		practice is still appropriate. The re		
		rs, extensive assist of one		will be shared with the facility QAF		
		res, and was always		committee for input on the need to		
		l. R1's MDS further indicated		increase, decrease or discontinue		
		e ulcers, and had a pressure		audits.		
	reducing device in o	chair and bed.		Corrections will be monitored by: DON/ADON/Nurse Managers/Des	ignee	
		w progress notes dated				
		Braden Scale assessment				
	(tool to assist in det breakdown) had be	termining risk of skin				
		made that R1 was at risk for				
		1's progress notes further				
		ree Stage 2 pressure injuries				
	(partial thickness lo					
		as a shallow open ulcer with a				
		l, without slough. May also				
		t or open/ruptured serumfilled				
		le of the left foot and ankle wheelchair footrest, and				
		een initiated. R1's progress				
		ndicated R1 was to be turned				
		very 2 hours, and checked for				
	bowel incontinence	and changed every 2 hours.				
	R1's care plan revie	ewed 7/27/20, indicated R1				
		breakdown related to impaired				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			5 1/1/10		С	
		00582	B. WING		07/2	9/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO MN 55792	DUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	current pressure in R1's care plan furth incontinent of bower assistance of with placked directives for repositioning, and obreakdown. R1's Kardex/care grace indicated R1 requirement bed mobility and tracelimination needs a group sheets lacker and off-loading R1. On 7/28/20, from 3 continuous observer off-loaded or significated in his wheel any time was approfe:43 p.m. nursing a starting to undress transferring R1 to be R1 was transferred movement from R1 R1 had no indication buttocks. On 7/28/20, at 7:03 to be repositioned eresident asks more repositioning inform sheets. NA-I stated toilets everyone which dinner, and after directions as significant in the property of the propositioning informs the stated toilets everyone which incontinuous observes the propositioning informs and after directions.	incontinence and had a jury to left outer foot and ankle. Jury to left outer foot and for foot of turning and off-loading to prevent skin. Jury to left outer foot and foot of turning and off-loading to prevent skin. Jury to left outer for foot outer for ansfers, and was to have assessed every 2 hours. R1's directives for repositioning. Jury to left outer foot and foot outer for ansfers, and was to have assessed every 2 hours. R1's directives for repositioning. Jury to left outer foot and foot outer for ansfers, and was to have and washed had not been cantly repositioned while chair. Change in position at extractional position and buttocks. In of skin breakdown on his foot on the group she usually repositions and en she starts her shift, before	2 900			
	not been reposition	ed or checked and changed er shift at 2:30 p.m. NA-E				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
005	582	B. WING			C 29/2020	
NAME OF PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE			
THE WATERVIEW PINES LLC		H STREET SO A, MN 55792	UTH			
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE F REGULATORY OR LSC IDENTIFY	RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
stated R1 was already up who usually was in bed, so when up, he was repositioned at the was already up, he did not go off-loaded. NA-E stated R1 sepositioned every 2 hours, a not get repositioned in 2 hours of presentioning. On 7/29/20, at 9:55 p.m. NA-total assistance with cares, in repositioning. On 7/29/20, at 1:13 p.m. region verified R1 was to be repositioned timely. RN-A velacked direction for reposition pretty much everyone is ever On 7/20/20, at 4:00 p.m. the (DON) stated there should have communication with shift changot out of bed so staff could be a total the pool of the poo	she would get him lat time. Since R1 et repositioned or should be and verified R1 did rs on this date. A stated R1 required neluding toileting and distered nurse (RN)-A ioned every 2 hours, kdown when not erified R1's Kardex ning R1, but said ry 2 hours. director of nursing ave been ange as to when R1 reposition him timely risk for skin R could be endistribute the lage re-distribute the lage re-distribution of pressure. ssment and Wound ected the care planth new skin concerns to nursing or CORRECTION: esignee, could review sure ulcers to assure sary	,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00582	B. WING		C 07/29/2020	
NAME OF I					0172	.5/2020
NAME OF I	PROVIDER OR SUPPLIER		STREET SO	STATE, ZIP CODE		
THE WAT	TERVIEW PINES LLC		MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 16	2 900			
	pressure ulcers. The designee, could condelivery of care; to eservices are implended pressure ulcer developments.	d to promote healing of the director of nursing, or aduct random audits of the tensure appropriate care and the nented; to reduce the risk for elopment.				
	(21) days.					
2 910	MN Rule 4658.0528 Incontinence	5 Subp. 5 A.B Rehab -	2 910			8/31/20
	have a continuous programment to recommend to recommend to recommend to recommend the comprehensive results and the comprehensive resident without an indwelling unless the resident that catheterization B. a resident where coives appropriate prevent urinary traces.	nce. A nursing home must program of bowel and bladder luce incontinence and the catheters. Based on the ident assessment, a nursing that: ho enters a nursing home g catheter is not catheterized s clinical condition indicates was necessary; and no is incontinent of bladder treatment and services to t infections and to restore as er function as possible.				
	by: Based on observatireview, the facility faincontinence cares	ent is not met as evidenced on, interview, and document ailed to ensure timely were provided for 2 of 3 reviewed for bowel and se.		F690 Bowel/Bladder Incontinence, Catheter, UTI Immediate Corrective Action: Resident #1 and #4 skin was chec ensure that they did not have any breakdown as a result of not receive	ked to	

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MILLIESC	ota Department of He	I				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE : COMPI	
		00582	B. WING		07/2	; 9/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO MN 55792	DUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 17	2 910			
2 910	R4's Admission Rec R4's diagnoses incl behavioral disturbation weakness. R4's annual Minimus 5/5/20, identified R4 cognition. R4's MD required extensive ostomy, and was all R4's Urinary Incont Catheter Care Area 5/8/20, indicated R4 and her elimination every two hours. R4's Kardex dated incontinent of blade Kardex directed state and check for incorduring the day and Kardex further direct ostomy every two hours. On 7/28/20, at 3:45 room, and she was was facing a nights holding a call light in On 7/28/20, at 3:47 observed to be onentered R4's room, the door. NA-G exit R4's door was left of the source of the source R4's door was left of the source of the source R4's door was left of the source	cord dated 7/29/20, indicated luded dementia without ince, heart failure and muscle arm Data Set (MDS) dated 4 had severely impaired in Section for further identified she assistance toileting, had an ways incontinent of bladder. In inence and Indwelling in Assessment (CAA) dated 4 had urinary incontinence, needs were to be assessed in a ways incontinence, and had an ostomy. The lift to assess elimination needs, attinence, every two hours rounds during the night. The coted staff to check R4's ours. p.m. R4 was observed in her seated in a wheelchair. R4 tand, near her bed, and was	2 910	incontinent cares per their schedu NAR-E, NAR-G, and NAR-I were educated on need to complete restoileting cares per NAR care shee Corrective Action as it applies to on The Policy and Procedure for Actionally Living remains current. All NARs will be re-educated on completing resident toileting cares NAR care sheet by 8/31/2020. All residents will be reviewed to enthat their toileting needs are on the care sheets. Date of Compliance: 8/31/2020. Recurrence will be prevented by: Audits of 5 residents will be conducted ax/week x 4, 2x/week x 4, and the x 4 to ensure that their toileting necompleted timely. The results will shared with the facility QAPI comminguation the need to increase, decidiscontinue the audits. Corrections will be monitored by: DON/ADON/Nurse Managers/Designed.	ident t. thers: vities of per sure to e NAR cted n weekly eds are be nittee for rease or	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
				С		
		00582	B. WING			9/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO MN 55792	UTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 910	On 7/28/20, at 4:17 person entered R4' person administere exited the room wit unidentified staff per room. The staff per to R4. The staff-per p.m. The resident wheelchair and factor on 7/28/20, at 5:09 dining room. At 6:1 and asked if she with continued to eat. At chair near R4 and in NA-F stated, "Go at then walked away from a staff and staff and saked if she with the stated in general and conducted with NA-usually incontinent, resident much. NA R4 was on a check stated in general, reand changed every had an ostomy, and two hours. NA-F staff and changed every had an ostomy was lated in general and changed every had an ostomy was lated in general and changed every had an ostomy was lated in general and changed every had an ostomy was lated in general and changed every had an ostomy was lated in general and changed every had an ostomy was lated in general and changed every had an ostomy was lated in general and changed every had an ostomy and it need transferred or toilet continent "sometime ostomy and it need transferred or toilet continent "sometime ostomy and it need transferred or toilet continent "sometime ostomy and it need transferred or toilet continent "sometime ostomy and it need transferred or toilet continent "sometime ostomy and it need transferred or toilet continent "sometime ostomy and it need transferred or toilet continent "sometime ostomy and it need transferred or toilet continent "sometime ostomy and it need transferred or toilet continent "sometime ostomy and it need transferred or toilet continent "sometime ostomy and it need transferred or toilet continent "sometime ostomy and it need transferred or toilet continent "sometime ostomy and it need transferred or toilet continent "sometime ostomy and it need transferred or toilet continent "sometime ostomy and it need transferred or toilet continent "sometime ostomy and it need transferred or toilet continent "sometime ostomy and it need transferred or toilet continent "sometime ostomy and it need transferred or toilet continent "sometime ost	r p.m. an unidentified staff is with medications. The staff and medications to R4 and hin a minute. At 4:19 p.m. the erson again entered R4's room administered eye drops roon exited R4's room at 4:20 remained seated in a ed a nightstand near her bed. I p.m. R4 was wheeled to the 2 p.m. NA-F approached R4 as finished eating. R4 at 6:22 p.m. NA-F placed a nquired how she was doing. head and finish eating." NA-F from R4. At 6:24 p.m. NA-F and encouraged her to drink NA-F wheeled R4 from the room. NA-F then exited R4's p.m. an interview was p.F. NA-F stated R4 was not but she didn't work with the p.F stated she was unsure if and change schedule. NA-F esidents were to be checked two hours. NA-F stated R4 d staff were to check it every tated she was unsure when	2 910			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		00582	B. WING		1	9/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO MN 55792	UTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	checked-and-chang stated she emptied this time, R4's ostom NA-G. R4's ostom NA-G stated it need from ostomy pouch from the ostomy poostomy pouch was with light brown sto incontinence produ would "normally" chincontinence produclean the shower row was waiting to use room. NA-G stated R4's ostomy pouch On 7/29/20, at 12:2 conducted with reg stated R4 was norman ostomy. RN-B scheck-and-change the day, and rounds stated you wound rouch to be one-hard RN-B stated staff wresident's incontine to be wet. RN-B st skin breakdown or infection if an inconchanged when soile On 7/29/20, at 3:53 conducted with the The DON stated R4 had an ostomy white The DON stated stand change R4 ever stated she would he state	ged every two hours. NA-G R4's ostomy at 6:30 p.m. At my pouch was observed with y pouch was filled with air and ded to be "burped" (release air). NA-G then released the air buch. NA-G confirmed R4's approximately one-half full ol. NA-G also confirmed R4's ot was "wet." NA-G stated she hange a resident's ot, however, she needed to bom because another resident it. NA-G then exited R4's I she did not document when was last emptied. If p.m. an interview was instered nurse (RN)-B. RN-B hally incontinent and also had stated staff were expected to R4 every two hours, during so during night shift. RN-B hot normally expect an ostomy of full of stool in an hour. I would be expected to change a ince product if it was identified ated a resident could have develop a urinary tract tinence product was not	2 910			

Minnesota Department of Health

STATE FORM 6899 UHW711 If continuation sheet 20 of 26

NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) (ACT DEFICIENCY OR LSC IDENTIFYING INFORMATION) 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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
THE WATERVIEW PINES LLC 1201 8TH STREET SOUTH VIRGINIA, MN 55792 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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			00582	B. WING			
CX4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE 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	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	THE WA	TERVIEW PINES LLC			UTH		
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	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	COMPLETE
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	incontinence product (ADLs), Supporting "Appropriate care a for residents who a independently, with and in accordance R1's Admission Rec R2's diagnoses inclaim hemiparesis followi (weakness or paralifollowing a stroke), cognitive functions posture, neuralgia a contracture of hand tendons, or ligamer movement of the af R1's quarterly MDS had moderately implecision making, had behaviors, required for bed mobility, total extensive assist of was always incontinurinary catheter. R1's quarterly reviee 7/27/20, indicated F wore an incontinent for bowel incontinent hours. R1's care plan review as incontinent of the provide incontinent bowel movement.	Activities of Daily Living dated 3/18, directed, and services will be provided re unable to carry out ADLs the consent of the resident with the plan of care" Cord printed 7/30/20, indicated uded hemiplegia and ang cerebral infarction ysis on one side of body signs and symptoms involving and awareness, abnormal and neuritis (nerve pain), and and (fixed tightening of muscle, and that prevents normal fected body part). I dated 5/4/20, indicated R1 paired cognitive skills for daily and no rejection of care extensive assist of two staff all assist of two for transfers, one staff for toileting cares, ment of bowel, and had a support of the care and changed every 2 Ewed 7/27/20, indicated R1 powel and directed staff to care after each incontinent R1's care plan lacked	2 910			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
				С		
		00582	B. WING		07/2	9/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO MN 55792	JUIN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 21	2 910			
	changing.					
	indicated R1 had a assistance of 2 stat	uide provided 7/28/20, urinary catheter, required if for perineal care and was to mination needs or checked for 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.					
	not been reposition since she started his stated R1 was alread usually was in bed, up, he would be reptime. Since R1 was repositioned or chabe repositioned and	p.m. NA-E verified R1 had ed or checked and changed er shift at 2:30 p.m. NA-E ady up when she started, and so when she would get him positioned and changed at that is already up, he did not get nged. NA-E stated R1 should dichecked or changed every 2 R1 did not get repositioned or on this date.				
		p.m. NA-A stated R1 required h cares, including toileting and				
	be checked and characterisk for skin brea	p.m. RN-A verified R1 was to anged every 2 hours, and was kdown. RN-A verified R1's check and change every 2				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1. 700			TE SURVEY MPLETED	
			A. BUILDING:	A. BUILDING:		,
		00582	B. WING		07/2	9/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		H STREET SOUTH A, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	On 7/20/20, at 4:00 (DON) stated there communication with got out of bed so st for incontinence timat risk for skin brea SUGGESTED MET The director of nurs review and revise p to ensuring appropriate incontinence. The designee, could destaff and develop a staff are providing to	p.m. the director of nursing should have been a shift change as to when R1 aff could reposition and check nely. The DON verified R1 was kdown. THOD OF CORRECTION: sing (DON), or designee, could colicies and procedures related riate care and services related ne director of nursing, or velop a system to educate monitoring system to ensure	2 910			
21375	Subpart 1. Infection home must establist control program desanitary environme. This MN Requirements: Based on observation review, the facility of hygiene during persontamination for 1 during incontinent of Findings include:	ent is not met as evidenced ion, interview, and document ailed to ensure proper hand sonal cares to prevent cross of 2 residents (R1) observed	21375	F880 Infection Prevention & Contr Immediate Corrective Action: NA-E received education on the pr process for sanitizing/washing her while performing peri care. Corrective Action as it applies to o The Policy and Procedure for Han Hygiene remains current. All NARs were re-educated on har	roper hands thers: d	8/31/20

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00582	B. WING		07/29	9/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS CITY S	STATE, ZIP CODE	1 0=	
			STREET SC			
THE WA	TERVIEW PINES LLC	VIRGINIA,	MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
21375	hemiparesis followin (weakness or paraly following a stroke), cognitive functions a posture, neuralgia a contracture of hand tendons, or ligamer movement of the af R1's quarterly Minin 5/4/20, indicated R1 cognitive skills for drejection of care be assist of two staff for two for transfers, extoileting cares, was and had a urinary control of the staff of two for transfers, extoileting cares, was and had a urinary control of the staff of two for transfers, extoileting cares, was and had a urinary control of the staff of two for transfers, extoileting cares, was and had a urinary control of the staff of two for transfers, extoileting cares, was and had a urinary control of two for transfers, extoileting cares, was and had a urinary control of the staff of two for transfers, extoileting cares, was and had a urinary control of the staff of two for transfers, extoileting cares, was and had a urinary control of the staff of two for transfers, extoileting cares, was and had a urinary control of the staff of two for transfers, extoileting cares, was and had a urinary control of the staff of two for transfers, extoileting cares, was and had a urinary control of two for transfers, extoileting cares, was and had a urinary control of two for transfers, extoileting cares, was and had a urinary control of two for transfers, extoileting cares, was and had a urinary control of two for transfers, extoileting cares, was and had a urinary control of two for transfers, extoileting cares, was and had a urinary control of two for transfers, extoileting cares, was and had a urinary control of two for transfers, extoileting cares, was and had a urinary control of two for transfers, extoileting cares, was and had a urinary control of two for transfers, extoileting cares, was and had a urinary control of two for transfers, extoileting cares, was and had a urinary control of two for transfers, extoileting cares, was and had a urinary control of two for transfers, extoileting cares, was and had a urinary control of two for transfers, exto	uded hemiplegia and ng cerebral infarction ysis on one side of body signs and symptoms involving and awareness, abnormal and neuritis (nerve pain), and (fixed tightening of muscle, nts that prevents normal fected body part). num Data Set (MDS) dated I had moderately impaired laily decision making, had no haviors, required extensive or bed mobility, total assist of always incontinent of bowel, atheter. We progress notes dated I have incontinent of bowel, and was to be checked note and changed every 2 Ewed 7/27/20, indicated R1 powel, and directed staff to care after each incontinent R1's care plan lacked ency of checking and uide provided 7/28/20, urinary catheter, required if for perineal care and was to mination needs or checked for	21375	hygiene, including hand hygiene we performing peri care. All NARs we educated on peri care and handway verbally, and via a video on peri care. All other staff will be educated on hygiene by 9/1/2020. Date of Compliance: 8/31/2020. Recurrence will be prevented by: In order to ensure the deficient pradoes not happen again, the DON designee, will conduct hand hygie audits, including NARS, performin handwashing while performing perion staff member from all shifts, exfor one week, weekly for 8 weeks, monthly for 2 months, then bring treview. Corrections will be monitored by: DON/ADON/Nurse Managers/Designer.	ere ashing are. hand actice or ne ng ri care, very day, , and o QA to	
		p.m. nursing assistant (NA)-I ting to undress and wash up				

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Minnesota Department of Health STATE FORM

PRINTED: 09/16/2020 FORM APPROVED

Minneso	<u>ota Department of He</u>	ealth earth				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00582	B. WING		07/2	9/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TWINE OF .	NOVIDEN ON COLL E.E.		STREET SO			
THE WAT	TERVIEW PINES LLC		, MN 55792	ЮТН		
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEI IOIERO I)		
21375	Continued From pa	ige 24	21375			
	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 ointmer					
	to R1's buttocks and rectal area. NA-E removed					
		and without performing hand				
		and put a clean incontinent				
		and NA-I turned R1 to his back				
		ight to remove the hoyer him. NA-E moved the canvas				
		I's wheelchair. NA-E put pillow				
		and put it under R1's calves.				
		s call light within his reach, and				
	-	f the bed. NA-E then washed				
		pathroom before exiting the				
		ot performed hand hygiene				
		soiled gloves following				
		and before touching clean				
	items.					
	On 7/28/20 at 7:07	p.m. NA-E verified she had				
		giene after removing gloves				
		ares, and before touching				
	clean items. NA-E	stated she was not sure when				
	to sanitize or wash	her hands.				
	On 7/20/20 at 4:42	on me registered names (DNI) A				
		B p.m. registered nurse (RN)-A tion was for hand hygiene to be				
		after perineal cares, and				
		clean tasks. RN-A stated staff				
		ves and sanitize, and reglove				
	going from dirty to					
	On 7/20/20 at 4:00) n m the director of nursing				
) p.m. the director of nursing should change gloves, and				
		ene when going from soiled to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
	00500	B. WING		07/0		
	00582	B. WING		07/2	9/2020	
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THE WATERVIEW PINES LLC		STREET SO , MN 55792	итн			
PREFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
directed infection conthygiene and would recepted potentially deadly gern to perform hand hygiene assisting a resident wound handling soiled or urinals, and after removed and the director of nursing review and revise polion appropriate indicate assure an infection contestablished, maintained care is provided to research and in a sanitary environment of the sanitar	ing another task. Ind Hygiene dated 6/17, Itrol begins with hand duce the spread of Ims. The policy directed staff Index ene before and after Index energy energy energy energy energy Index energy energy energy Index energy energy energy Index energy Index energy energy Index en	21375				

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