

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 18, 2020

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

RE: CCN: 245283

Cycle Start Date: November 4, 2020

Dear Administrator:

On November 24, 2020, we notified you a remedy was imposed. On December 17, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 4, 2020.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective January 8, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 24, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 8, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 4, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed 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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 24, 2020

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

RE: CCN: 245283

Cycle Start Date: November 4, 2020

Dear Administrator:

On November 4, 2020, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 8, 2021.
- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 8, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 8, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is

your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION (Delete this section if SQC tags are cited and this note)

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 8, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Waterview Pines Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 8, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us

Phone: (218) 302-6151

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 4, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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: 12/07/2020 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 11/04/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792	11/04	HZUZU
(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) COMPLETION DATE
E 000	Initial Comments		E 00	00		
	was conducted 11/2 facility by the Minne determine complian	sed Infection Control survey 2/20, through 11/4/20, at your esota Department of Health to ace with Emergency lations §483.73(b)(6). The compliance				
		nrolled in ePOC, your uired at the bottom of the first 567 form.				
F 000			F 00	00		
	survey and a COVII Control survey were the Minnesota Depa if your facility was in requirements of 42 Requirements for L	h 11/4/20, an abbreviated D-19 Focused Infection e conducted at your facility by artment of Health to determine a compliance with CFR Part 483, Subpart B, and ong Term Care Facilities. The e facility was NOT in				
	The following comp H5283030C	laint was substantiated:				
	as your allegation of Department's acception enrolled in ePOC, year the bottom of the	f correction (POC) will serve f compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.				
ABORATORY	' DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X	(6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

12/04/2020

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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
		245283	B. WING		11	C / 04/2020
	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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to intial compliance with the	F(000		
F 580 SS=D			F	580		12/4/20

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) 04/2020
	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 580	(B) A change in res State law or regular (e)(10) of this sectic (iv) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a conthat is a composite §483.5) must disclose its physical configual locations that composite yeart, and must speroom changes betwounder §483.15(c)(9) This REQUIREMED by: Based on interview facility failed to notive weight gains as ordereviewed for notifice. R3's Admission Re R3's diagnoses ince (CHF) and chronice. R3's significant change and chronice. R3's significant change and chronice. R3's significant change and chronice. R3's care plan lack were to be perform.	ident rights under Federal or tions as specified in paragraph on. It record and periodically (mailing and email) and he resident Inposite distinct part. A facility distinct part (as defined in ose in its admission agreement ration, including the various orise the composite distinct cify the policies that apply to ween its different locations). NT is not met as evidenced or and document review, the fix the physician of a resident's lered for 1 of 3 residents (R3) action of change. Cord dated 11/4/20, indicated luded congestive heart failure kidney disease. Inge Minimum Data Set (MDS) tified R13 had intact cognition. Identified he received diuretic ion on seven days.	F 580	F Tag: F580 Notification Immediate Corrective Action: Resident #3 MD was notified of h gain as soon as the discrepancy v identified. Staff identified as having a pattern recording a weight for Resident # counseled and re-educated on the importance of obtaining and record daily weights if ordered and docur any resident refusals. Corrective Action as it applies to a The Policy and Procedure for Cha Resident Condition which include notification was reviewed and rem current. All residents were reviewed to as notification with any condition chan occurred timely. Condition chan a focus topic reviewed and discus	n of not 3 were e rding menting others: ange in s MD nains sure MD inge e will be	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245283	B. WING)4/ 2020
	PROVIDER OR SUPPLIER			S 1:	TREET ADDRESS, CITY, STATE, ZIP CODE 201 8TH STREET SOUTH //IRGINIA, MN 55792	1 1170	J4/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	directed the facility notify the heart centwo pounds in a day. The order was disc of R3's MAR's from following: -R3's weight was not pounds on 9/4/20, the was documented R taken on 9/5/20, and on 9/6/20. -R3's weight was not pounds on 9/21/20, -R3's weight was not pounds on 10/7/20, -R3's weight was not pounds on 10/27/20. It was documented R3 reform 10/28/20, and not 10/28/20, and not 10/29/20, and 10. Review of R3's meeting heart center phyweight increases or On 11/3/20, at 3:16 conducted with R3. staff didn't forgot to didn't refuse to have "everything to do with the conducted with nurstated R3 was to have the stated R3 was to h	was to take daily weights, and ter if R3's weight increased y, or five pounds in a week. ontinued on 11/4/20. Review 19/1/20, to 11/4/20 revealed of the total to increase from 181.4 to 185.6 pounds on 9/7/20. It is refused to have his weight id no weight was documented of the total to increase from 180.6 to 183.8 pounds on 9/22/20. Onted to increase from 179.8 to 184.4 pounds on 10/8/20. Onted to increase from 177.6 to 181 pounds on 10/31/20. Fused to have his weight taken to weights were documented 0/30/20. Idical record lacked indication yisician was notified of R3's in the above dates. p.m. an interview was R3 stated he believed facility take his weight. R3 stated he e his weight taken as ith my health is important." p.m. an interview was sing assistant (NA)-B. NA-B ave his weight taken daily. Its were documented in the	F	580	morning stand-up. All nursing staff will be re-educated Change in Resident Condition Policithe need to notify MD timely, docur any resident treatment refusals and their supervisor. Date of Compliance: 12/4/2020 Recurrence will be prevented by: All residents with any condition chawill be reviewed weekly x 4 weekly monthly x 2 months to assure MD notification occurred, documentation present, refusals documented and supervisor notified. The results of audits will be shared with the facilit Committee for input on the need to increase, decrease or discontinue audits. Corrections will be monitored by: DON/Unit Managers	cy and ment d notify ange then on is these	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		245283	B. WING		11/04/	2020
	PROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792	, -	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CO	(X5) DMPLETION DATE
F 580	On 11/4/20, at 11:0 conducted with lice LPN-C stated R3 w daily, however, son stated nursing community the NAs to the last resident's record. On 11/4/20, at 11:1 conducted with reg confirmed R3 was taken daily. RN-B rand confirmed doc missing. RN-B stawhere a weight was subsequently not c RN-B stated she w not taken, however be "repeat offender weights were not d was not known to r RN-B confirmed R3 of a two pound weights were not do regarding physician R3's physician showeights were not taken, "If it's not do regarding physician R3's physician showeights were not taken, "If it's not do regarding physician R3's physician showeights were not taken, "If it's not do regarding physician R3's physician showeights were not taken, "If it's not do regarding physician R3's physician showeights were not taken, "If it's not do regarding physician showeights were not taken," If it's not do regarding physician showeights were not taken, "If it's not do regarding physician showeights were not taken," If it's not do regarding physician showeights were not taken, and the properties of the p	9 a.m. an interview was ensed practical nurse (LPN)-C. was to have his weight taken netimes he refused. LPN-C upared the weight provided by documented weight in a 9 a.m. an interview was istered nurse (RN)-B. RN-B ordered to have his weight eviewed R3's medical record umentation of weights were ted there was likely instances	F 580			

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 11/0	4/2020
	ROVIDER 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	there was a risk for The facility policy C dated 6/19, directed resident/representa provider of changes and/or status." Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of care is a applies to all treatm facility residents. Ba assessment of a re that residents recei accordance with pro practice, the compr care plan, and the r This REQUIREMEN by: Based on interview facility failed to cone and monitor blood p (R1) who was hypo pressure). In addition daily weights for 1 of Findings include: Assessment/Blood R1's Admission Rec	esident had a weight gain as fluid overload. hange in Resident Condition d, "The facility shall notify the tive and physician/healthcare in the resident's condition care fundamental principle that tent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of ehensive person-centered residents' choices. NT is not met as evidenced and document review, the duct follow-up assessments oressures for 1 of 3 residents tensive (had low blood on, the facility failed to obtain of 3 residents (R3). Pressure cord dated 11/4/20, indicated uded heart failure, atrial	F 58		g the n a /eight s not ere	12/4/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			7 ti BOILE			(
		245283	B. WING				4/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC				201 8TH STREET SOUTH		
				V	/IRGINIA, MN 55792	. 1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From pa	ae 6	F 6	84			
	-	imum Data Set (MDS) dated	. `		Corrective Action as it applies to other	ners:	
		R1 had intact cognition.			The Policy and Procedure for Chan		
		· ·			Resident Condition was reviewed a		
		ministration Record (MAR)			remains current. The Policy and	L	
		0/20, directed encourage fluid			Procedure for Resident Weight Eva was reviewed and remains current.		
	intake, every shirt, a	as blood pressure was low.			All residents were reviewed to assu		
	R1's ADL (activities	of daily living) Functional /			notification with any condition change		
		ntial Care Area Assessment			occurred timely, as well as complet		
		0, indicated R1 was working			any follow-up assessments indicate		
		rove her strength and overall			documentation of any treatment ref		
		The CAA further indicated to be discharged home,			is present and notification of superv condition changes or treatment refu		
		d cognition were potential			Condition change will be a focus to		
	barriers.	g			reviewed and discussed at morning		
					stand-up.		
		d 8/26/20, indicated R1 had			All nursing staff will be re-educated		
		natological (blood) status. The			Change in Resident Condition Police		
	ordered, and monit	o give medications, as			the Resident Weight Evaluation Po and the need to notify MD timely, in		
	effects/effectivenes				any follow-up assessments, docum		
					any resident treatment refusals and		
		od pressures revealed the			their supervisor for condition chang	es or	
	following:				treatment refusals.		
		re was documented as 76/46			Date of Compliance: 12/4/2020 Recurrence will be prevented by:		
	on 9/9/20, at 10:27	p.m. re was documented as 88/54			All residents with any condition cha	nge	
	on 9/9/20, at 11:14				will be reviewed weekly x 4 weeks to		
		re was documented as 92/72			monthly x 2 months to assure MD		
	on 9/10/20, at 3:01				notification occurred, follow-up		
		es were documented from			assessments are initiated, docume		
	9/11/20, to 9/13/20.	re was documented as 70/40			is present, refusals documented an supervisor notified. The results of t		
	on 9/14/20, at 12:55				audits will be shared with the facility		
	2.7 0, 1 1,20, 00 12.00	- F			Committee for input on the need to	~ · · ·	
		ted 9/11/20, at 5:55 p.m.			increase, decrease or discontinue t	he	
		telehealth visit with her			audits		
		h under her left breast." The er indicated there were, "No			Corrections will be monitored by: DON/Unit Managers		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C		
		245283	B. WING _		11	/04/2020
	PROVIDER OR SUPPLIER			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 AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	other concerns at the A document titled E Care dated 9/11/20 consultation was consultation was consultation was "rath further indicated R her blood pressure 92/72. Nursing was see if helps." R1 reactions and indicated R1 was "to stand independe R1 was unable to k questions. R1's vitic pressure was "low," and an order was demergency departricts standing outside of A progress note daindicated R1's repressure was "bad." The progress note daindicated R1's representative visited with family canswered "yes and Review of R1's mer follow-up assessment 9/11/20, to 9/13/20. On 11/2/20, at 4:12 conducted with lice LPN-A stated some other times she was consultations.	Essentia Health - Virginia Elder , indicated a telemedicine ompleted with R1's physician. Cated nursing reported R1's er poor." The document I "was not drinking a lot" and s were 88/54, 76/46, and s "going to push fluids a bit to exported feeling "fine." Ited 9/14/20, at 12:56 p.m. Very lethargic" and was unable ntly "as she had been doing." eep her eyes open to answer al signs indicated her blood "R1's physician was notified obtained to send R1 to the nent. R1's daughter was R1's window. Ited 9/14/20, at 1:00 p.m. essentative updated the facility ere infection) and R1's urine or	F 68			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245283	B. WING			C / 04/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 1201 8TH STREET SOUTH VIRGINIA, MN 55792		10-H2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 684	condition. On 11/3/20, at 12:2 conducted with fam R1 tripped on a car (vertebrae) fracture facility. F-A stated for bedrest and the spoke to R1 on 9/13 F-A stated sometim 9/14/20, "Somethin stated she received told R1 was going to department. F-A stand looked through was unable to hang was "weak" and "look was moaning. F-A R1's window for throwere in R1's room. registered nurse (R R1's blood pressure three people then of quickly." F-A stated the hospital. F-A stated the hospital. F-A stated the hospital. F-A stated the hospital. F-A stated fR1's urine looked lill R1 had a lack of ox severely dehydrated been discharged froadmitted to hospice. On 11/3/20, at 3:09 conducted with LPN a lot of cares and with the state of the survive o	6 p.m. an interview was illy member (F)-A. F-A stated pet and suffered a T11 prior to admission to the R1 was admitted to the facility rapy. F-A stated her sister 2/20, and R1 was "doing fine." lee between 9/12/20, and g happened to her [R1]." F-A I a call on 9/14/20, and was to be sent to the emergency ated she went to the facility R1's window. F-A stated R1 tonto a phone because she oked gray." F-A stated R1 stated she stood outside of the et of five minutes and no staff F-A stated she called N)-A and she was informed to was "really low." F-A stated ame to R1's room "very I she then left to meet R1 at ated once at the hospital, the R1 was not expected to ked like she was dying. F-A R1's blood pressure was R1 had a catheter placed and ke "creamed corn." F-A stated ygen to her brain and was d. F-A stated R1 had since to the hospital and was	F6	i84		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245283	B. WING			C I1/04/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 1201 8TH STREET SOUTH VIRGINIA, MN 55792		11/04/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE CORRECTION OF CO	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 684	in condition for R1. report a low blood preserved and encould LPN-B stated she whad a low blood preserved at low be sent out becaus previously was. RN-December 1 low be sent out becaus previously was. RN-December 1 low blood preserved at low blood preserved at low blood pressure read frequency of blood dependent upon recresident's blood preserved.	LPN-B stated she would bressure reading to her unit curage a resident to drink fluids. Would reassess a resident, who essure, every 15 minutes. p.m., an interview was stered nurse (RN)-A. RN-A itted to the facility for action. RN-A stated R1 was a ady" and told staff not to "bug" ognitive testing was conducted etermined R1 had dementia. As informed on 9/14/20, ong" with R1. RN-A stated R1 ever, R1 verbalized she was R1's daughter was at R1's. RN-A stated R1 needed to be she was not as alert as she land stated R1 had a "bad" on. RN-A stated R1 had a "bad" on. RN-A stated R1 had a "bad" on. RN-A stated R1's family as "really talkative" on 9/12/20, anable to hold a telephone on ed she spoke with staff who and nurse told her R1 didn't self" and R1 was "sleepier." as unable to recall who the	F 6	84		

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 11/04/2020		
	PROVIDER OR SUPPLIER TERVIEW PINES LLC			120	EET ADDRESS, CITY, STATE, ZIP CODE 1 8TH STREET SOUTH GINIA, MN 55792	1 117	04/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 684	RN-A stated staff "R R1's blood pressure On 11/4/20, at 12:4 conducted with the The DON stated stafollow-up assessme were identified. The consultant had revidetermined staff ne pressures, and upd DON stated R1 was it was reported R1 DON stated "most" change of condition The DON stated star RN or leave a note a resident had a ch stated staff education. The facility policy C dated 6/19, directed physician/healthcar make detailed obseand pertinent inform Weights R3's Admission Rec R3's diagnoses incl (CHF) and chronic R3's significant chaidentified R3 had in further identified he (water pill) on severe	probably" should had followed a more closely. 5 p.m. an interview was director of nursing (DON). In the series when abnormal values are DON stated a corporate lewed R1's medical record and reded to recheck R1's blood late the medical provider. The series "good" on 9/12/20, however, was "sleepy" on 9/13/20. The nurses' were educated on an and what sepsis looked like. In the clinical manager when ange of condition. The DON on was started on 11/3/20. Thange in Resident Condition of the provider, the nurse will be revations and gather relevant the provider of the provider. The provider of the provider	F 6	84				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245283	B. WING				C 04/2020
	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 201 8TH STREET SOUTH /IRGINIA, MN 55792	,	772020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From pa		F 6	84			
	directed R3 was to due to CHF. The o	ministration record (MAR) have his weight taken daily rder was discontinued on R3's MAR's from 9/1/20, to bllowing:					
	9/10/20, 9/11/20, 9/ 9/19/20/ 9/23/20, 9/ 10/14/20, 10/16/20, 10/22/20, 10/25/20, and 11/3/20. -Weights were docu	ocumented on 9/3/20, 9/6/20, 12/20, 9/13/20, 9/18/20, 12/20, 9/13/20, 10/6/20, 10/17/20, 10/20/20, 10/21/20, 10/29/20,10/30/20, 11/1/20, umented as refused on 9/5/20, 15/20 and 10/28/20.					
	conducted with R3. staff didn't forgot to didn't refuse to have	p.m. an interview was R3 stated he believed facility take his weight. R3 stated he e his weight taken as ith my health is important."					
	conducted with NA- have his weight tak	p.m. an interview was B. NA-B stated R3 was to en daily. NA-B stated weights n the electronic medical					
	conducted with LPN	9 a.m. an interview was N-C. LPN-C stated R3 was to en daily, however, sometimes					
	conducted with RN ordered to have his reviewed R3's med documentation of w	9 a.m. an interview was -B. RN-B confirmed R3 was weight taken daily. RN-B ical record and confirmed reights were missing. RN-B ely instances where a weight					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILT		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245283	B. WING _			C 04/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		-112020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	TION SHOULD BE THE APPROPRIATE	
	communicated to the unsure why weights verbalized there appled offenders" on the dadocumented. RN-E refuse having his weighted the staff were identified regarding R3's weighted staff were identified regarding R3's weighted staff were expected or document a resident refused document needed to the facilities to obtain an upon admission or inshall be done for ear often according to the consensus between Infection Prevention CFR(s): 483.80 (a) (a) \$483.80 Infection CT applied to provide the resident of the prevention designed to provide the staff were expected to the staff were expected to a resident refused to the staff were expected to be a resident refused to the staff were expected to be a resident refused to a resid	and subsequently not be next shift. RN-B she was a were not taken, however, peared to be "repeat ates in which weights were not a stated R3 was not known to eight taken. 5 p.m., an interview was DON. The DON stated two as being "offenders" phts. The DON stated one ready reeducated. The DON pected to obtain weights, as ent refusals. The DON stated at a risk versus benefits to be completed. esident Weight Evaluation at a management Rehabilitation of accurate weight of residents readmission. Further, weights are the interdisciplinary team." a & Control 1)(2)(4)(e)(f) ontrol tablish and maintain an and control program a safe, sanitary and	F 68			12/4/20
	development and tr diseases and infect	nment and to help prevent the ansmission of communicable ions. n prevention and control				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		245283	B. WING _		11	C / 04/2020	
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC				STREET ADDRESS, CITY, STATE, ZIP C 1201 8TH STREET SOUTH VIRGINIA, MN 55792			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 880	and control program a minimum, the foll §483.80(a)(1) A system of conducted according accepted national states and communicable staff, volunteers, visproviding services arrangement based conducted according accepted national states and communication accepted national states are not limited to (i) A system of survive possible communication and the persons in the facilia (ii) When and to who communicable diserve of the followed to provide to be followed to provide to provide to be followed to provide to be followed to provide to provide to the followed t	tablish an infection prevention in (IPCP) that must include, at owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual if upon the facility assessmenting to §483.70(e) and following standards; en standards, policies, and program, which must include, or eillance designed to identify table diseases or ey can spread to other sty; tom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a	F 88				

		IDENTIFICATION NUMBER.		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C 11/04/2020	
	245283					
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792	1110412020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE CO	(X5) DMPLETION DATE
F 880	contact will transmir (vi)The hand hygier by staff involved in sections that \$483.80(a)(4) A system identified under the corrective actions to \$483.80(e) Linens. Personnel must have transport linens so infection. §483.80(f) Annual or The facility will conclete and update the This REQUIREMENT by: Based on observative review, the facility fawas completed during prevent cross contact (R5) reviewed for bincontinence. Findings include: R5's Diagnoses Re R5's diagnoses include: R5's quarterly Minimal 10/8/20, identified Facility dependent up always incontinent of the staff of the staf	the disease; and he procedures to be followed direct resident contact. Stem for recording incidents facility's IPCP and the aken by the facility. Indle, store, process, and as to prevent the spread of duct an annual review of its heir program, as necessary. NT is not met as evidenced sion, interview, and document hailed to ensure hand hygiene ing incontinence cares to amination for 1 of 3 residents owel and bladder.	F 88	F Tag: F880 DPOC Immediate Corrective Action: NA-C was counseled and re-educa with return demonstration compete the Hand Hygiene Policy on 11/4/2 Corrective Action as it applies to ot All residents have the potential to be affected by the deficient practice. facility QAPI Committee conducted Cause Analysis of the deficient pra and developed a corrective action prevent recurrence. The Policy and Procedure for prop Hand Hygiene was reviewed and re current with CDC guidelines. All staff to include the DON and Inf Preventionist will receive re-educat the Hand Hygiene Policy and Proce Transmission based precautions a	hers: hers: he The a Root ctice olan to er emains ection ion on edure,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			, BOILBII			С	
		245283	B. WING_			11/04/2020	
NAME OF F	PROVIDER OR SUPPLIER		' I	STREET ADDRESS, CITY, STATE, ZIP COI			
TI I				1201 8TH STREET SOUTH			
THE WAI	TERVIEW PINES LLC			VIRGINIA, MN 55792			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETION DATE	
F 880	Continued From pa	age 15	F 88	30			
	•	staff to provide incontinence		equipment. Resources from	CDC and		
	care after each inco			MDH will be utilized for the re			
				The DON, Infection Prevention			
	On 11/4/20, at 10:3	9 a.m. nursing assistant		Clinical Education Coordinate			
		's room, provided privacy, and		conduct return demonstration			
		ves. NA-C transferred R5		competencies on proper hand			
		to a bed, using a mechanical		with all staff and maintain a lo	g with		
		wered R5's pants and		results.	00		
		piled incontinence product.		Date of Compliance: 12/4/20			
		wipes, cleaned R5's groin of the wet wipes in a garbage		Recurrence will be prevented The DON, Infection Prevention	•		
		R5 was "wet," and encouraged		other leadership staff will con-			
		de rail. NA-C pushed on R5's		on all shifts, every day for one			
		to her left side. NA-C used an		assure proper infection control			
		R5's soiled incontinence		are being followed including h			
		ol off of R5's buttocks. NA-C		hygiene. The results of the a			
	then partially rolled	R5's soiled incontinence		shared with the facility QAPI	Committee		
		it out from under R5. The		and based on the results, the			
		product remained on R5's		continue daily or decrease in			
		d additional wet wipes,		and be discontinued once 100)%		
		cks, and placed each wet wipe		compliance is demonstrated.	I		
		tinence product which was on		Corrections will be monitored DON and Infection Prevention			
		sposed of the soiled ct in a garbage. Without		DON and injection Prevention	IISL		
		performing hand hygiene,					
		ean incontinence product and					
		nder R5. NA-C instructed R5					
		and R5 let go of the bed rail.					
		blue sweater near R5's right					
	shoulder, and brief	y held R5's right hand with her					
		NA-C walked to R5's left side					
		Il to her right side by pushing					
		er soiled gloved hands. NA-C					
		continence product from under					
		n R5's blue sweater with her					
		s. R5 again rolled to her back.					
		he package of wet wipes and another pair of gloves." NA-C					
		nd hygiene or obtain new					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245283	B. WING		C 11/04/2020		
	NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC			STREET ADDRESS, CITY, STATE, ZIP CO 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	gloves. R5 grabber wiped R5's inner th R5's incontinence producted with registated hand hygien after performing inconducted with NA-needed to perform gloves after she per R5. NA-C stated should be she were expected to with the were expected be wiped and he instructed NA-C to wash her hands. On 11/4/20, at 11:0 conducted with registated hand hygien after performing incompartment of the should be shown as the performing incompartment of the should be sh	d additional wet wipes and ighs. NA-C started to fasten broduct. At 10:52 a.m. the (DON) entered R5's room. It is bathroom, washed her is bathroom, washed hard R5 was rolled in pants were raised. The DON remove her gloves and again in a man interview was is tered nurse (RN)-B. RN-B is tered nurse (RN)-B. RN-B is needed to be completed continence cares. RN-B stated is contamination if staff failed to ene. 2 a.m. an interview was contamination if staff failed to ene. 5 p.m. an interview was interv	F 8	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND ADED		IULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		245283	B. WING	B. WING		C 11/04/2020	
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC			STREET ADDRESS, CITY, STATE, ZIP CO 1201 8TH STREET SOUTH VIRGINIA, MN 55792	ODE			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 24, 2020

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

Re: State Nursing Home Licensing Orders

Event ID: XH1Q11

Dear Administrator:

The above facility was surveyed on November 2, 2020 through November 4, 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
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us

Phone: (218) 302-6151

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

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		С		
		00582	B. WING			4/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE WAT	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	
2 000	Initial Comments		2 000				
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correspursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been					
	that may result from orders provided that the Department with	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 conduct with State Licensur NOT in compliance Please indicate in y correction that you	rs: n 11/4/20, an abbreviated ted to determine compliance e. Your facility was found to be with the MN State Licensure. rour electronic plan of have reviewed these orders, e when they will be completed.					

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

Electronically Signed 12/04/20

STATE FORM 6899 If continuation sheet 1 of 17 XH1Q11

TITLE

(X6) DATE

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00582	B. WING		11/0	2 4/2020
	PROVIDER OR SUPPLIER	1201 8TH	DDRESS, CITY, S STREET SO A, MN 55792	STATE, ZIP CODE B 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED: The facility is enroll signature is not req page of state form. On 11/2/20, through Department's staff, the following correct Please indicate in y correction that you	laint was found to be H5283030C ed in ePOC and therefore a uired at the bottom of the first 11/4/20, surveyors of this visited the above provider and tion orders are issued. our electronic plan of have reviewed these orders, a when they will be completed.				
2 265	•	5 Notification of Chg in	2 265			12/4/20
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, ar attending physician development of the	st develop and implement off decisions to consult of assistants, and nurse known, notify the resident's of an interested family ont's acute illness, serious At a minimum, the director of ond the medical director or an must be involved in the one policies. The policies must address at least the tion times for:				
		involving the resident which has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ation in health, mental, or in either life-threatening Il complications;				

6899

Minnesota Department of Health STATE FORM

Minneso	<u>ita Department of He</u>	alth				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMPI	LETED
					l c	•
		00582	B. WING		1	4/2020
					1170	112020
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
THE WAT	TERVIEW PINES LLC		STREET SC	DUTH		
		VIRGINIA,	MN 55792			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES		COMPLETE DATE
TAG	NEGOLATORT OR E	OCIDENTIF TING IN CHWATION)	TAG	DEFICIENCY)	NAIL	
	_					
2 265	Continued From pa	ge 2	2 265			
	C. a need to al	ter treatment significantly, for				
		discontinue an existing form				
		adverse consequences, or to				
	begin a new form o					
	bogiii a now ionii o	r a dament,				
	D. a decision t	o transfer or discharge the				
	resident from the n					
		3 ,				
	E. expected and unexpected resident deaths.					
	'	·				
	This MN Requireme	ent is not met as evidenced				
	by:					
		and document review, the		F Tag: F580 Notification		
		fy the physician of a resident's		Immediate Corrective Action:		
		ered for 1 of 3 residents (R3)		Resident #3 MD was notified of his	s weight	
	reviewed for notification	ation of change.		gain as soon as the discrepancy w	as	
				identified.		
	Findings include:			Staff identified as having a pattern	of not	
				recording a weight for Resident #3		
		cord dated 11/4/20, indicated		counseled and re-educated on the		
		uded congestive heart failure		importance of obtaining and record		
	(CHF) and chronic	kidney disease.		daily weights if ordered and docum	nenting	
	DOI : :6:	M: : D (0 (MD0)		any resident refusals.		
		nge Minimum Data Set (MDS)		Corrective Action as it applies to o		
		tified R13 had intact cognition.		The Policy and Procedure for Cha		
		lentified he received diuretic		Resident Condition which includes		
	(water pill) medicati	on on seven days.		notification was reviewed and rem	ains	
	DOL	. 12. 12 12 1. 26		current.	MD	
		ed indication daily weights		All residents were reviewed to ass		
	were to be perform	ea.		notification with any condition char		
	D01			occurred timely. Condition change		
		ministration record (MAR)		a focus topic reviewed and discuss	seu at	
	_	was to take daily weights, and		morning stand-up.	d = == 41 ·	
		ter if R3's weight increased		All nursing staff will be re-educated		
		y, or five pounds in a week.		Change in Resident Condition Poli		
		ontinued on 11/4/20. Review		the need to notify MD timely, docu		
		9/1/20, to 11/4/20 revealed		any resident treatment refusals an	d notify	
	following:			their supervisor.		ı

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 3 of 17 XH1Q11

Minnesota Department of Health

STATEMENT OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		С		
		00582 B. WING		11/04/2020			
NAME OF PROVID	DER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
THE WATERV	IEW PINES LLC		STREET SO MN 55792	DUTH			
	(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 APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
-R3' pour was take on 9 -R3' pour -R3' pour -R3' pour lt wa dock on 1 on 1 Revi the I weig On cond staff didn "eve On cond state NA-I elect	nds on 9/4/20, to documented R documented R en on 9/5/20, and 16/20. It was not not on 10/7/20, s weight was not not on 10/7/20, s weight was not not on 10/27/20 as umented R3 refunds on 10/27/20 as umented R3 refunds on 10/29/20, and not not	oted to increase from 181.4 of 185.6 pounds on 9/7/20. It is refused to have his weight do no weight was documented of the documented of the documented of the documented of the 183.8 pounds on 9/22/20. Oted to increase from 179.8 to 184.4 pounds on 10/8/20. Oted to increase from 177.6 of the documented of the documen	2 265	Date of Compliance: 12/4/2020 Recurrence will be prevented by: All residents with any condition ch be reviewed weekly x 4 weekly the monthly x 2 months to assure MD notification occurred, documentati present, refusals documented and supervisor notified. The results of audits will be shared with the facili Committee for input on the need to increase, decrease or discontinue audits. Corrections will be monitored by: DON/Unit Managers	on is I these ty QAPI		

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					С	
		00582	B. WING		11/0	4/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO MN 55792	итн		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 265	Continued From pa	ge 4	2 265			
	conducted with regiconfirmed R3 was of taken daily. RN-B regard confirmed documissing. RN-B statement where a weight was subsequently not confirmed she was not taken, however be "repeat offender weights were not downs not known to regard to pound weight to be the confirmed R3 of a two pound weight stated, "If it's not do regarding physician R3's physician should be taken to be the confirmed R3 of a two pound weight the confirmed R3 of a two pounds are should be the co	9 a.m. an interview was istered nurse (RN)-B. RN-B ordered to have his weight eviewed R3's medical record amentation of weights were sed there was likely instances is not obtained and ommunicated to the next shift. as unsure why weights were verbalized there appeared to s" on the dates in which ocumented. RN-B stated R3 efuse having his weight taken. B's physician was to be notified ght increase in a day. RN-B ocumented, it is not done in notification. RN-B stated ald had also be notified when ken, and R3 had a weight				
	conducted with the The DON stated tw "offenders" regarding stated one staff-per The DON stated state weights, as ordered DON stated if a responding stated of a responding stated staff with physician when a responding there was a risk for The facility policy C dated 6/19, directed resident/represental	5 p.m. an interview was director of nursing (DON). o staff were identified as being ng R3's weights. The DON reon was already reeducated. aff were expected to obtain d, or document refusals. The ident refused, a risk versus needed to be completed. The ere expected to update the esident had a weight gain as fluid overload. thange in Resident Condition d, "The facility shall notify the attive and physician/healthcare in the resident's condition				

Minnesota Department of Health

STATE FORM 6899 XH1Q11 If continuation sheet 5 of 17

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			71. BOILESING.			,	
		00582	B. WING		1	4/2020	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THE WA	THE WATERVIEW PINES LLC 1201 8TH VIRGINIA			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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 265	Continued From pa	ige 5	2 265				
	The Director of Nur could develop, revi- procedures to ensu- representatives/phy change in condition designee, could ed the policies and pro- designee, could de ensure ongoing con	ysicians are notified of a nor treatment. The DON, or ucate all appropriate staff on ocedures. The DON, or velop monitoring systems to					
2 830	Proper Nursing Ca	0 Subp. 1 Adequate and re; General general. A resident must	2 830			12/4/20	
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as de: 4658.0405. A nurs of bed as much as written order from t	e and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident					
	by: Based on interview facility failed to con and monitor blood	ent is not met as evidenced and document review, the duct follow-up assessments pressures for 1 of 3 residents stensive (had low blood		F Tag: F684 Quality of Care Immediate Corrective Action: Immediate education for all license nurses began on 11/3/2020 regard			

Minnesota Department of Health

STATE FORM 6899 XH1Q11 If continuation sheet 6 of 17

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<u> </u>	COMPL	EIED
		00582	B. WING		C 11/04	1/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
THE WAT	TERVIEW PINES LLC		STREET SC	DUTH		
			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	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 6	2 830			
	pressure). In additional daily weights for 1 confirmed from the findings include:	on, the facility failed to obtain of 3 residents (R3).		need for follow up assessments w resident was hypotensive as was displayed by Resident #1. Resident #3 MD was notified of his		
	Assessment/Blood	Pressure		gain as soon as the discrepancy wildentified.	/as	
	R1's Admission Rec R1's diagnoses incl fibrillation (irregular hypertension. R1's admission Min 8/18/20, identified F R1's Medication Ad dated 9/1/20, to 9/3 intake, every shift, a R1's ADL (activities Rehabilitation Poter (CAA) dated 8/20/2 with therapy to importunctional abilities.	cord dated 11/4/20, indicated uded heart failure, atrial heart rhythm), and imum Data Set (MDS) dated R1 had intact cognition. ministration Record (MAR) 0/20, directed encourage fluid as blood pressure was low. of daily living) Functional / ntial Care Area Assessment 0, indicated R1 was working rove her strength and overall The CAA further indicated		Staff identified as having a pattern recording a weight for Resident #3 counseled and re-educated on the importance of obtaining and record daily weights if ordered and docum any resident refusals. Corrective Action as it applies to on The Policy and Procedure for Chan Resident Condition was reviewed remains current. The Policy and Procedure for Resident Weight Evwas reviewed and remains current All residents were reviewed to assonotification with any condition chard occurred timely, as well as completany follow-up assessments indicated documentation of any treatment represent and notification of supervisions.	ding henting thers: nge in and valuation t. ure MD nge etion of ted, efusals is sor of	
	however, safety and barriers. R1's care plan date an alteration in hem care plan directed to ordered, and monitoreffects/effectiveness. Review of R1's blood following: - R1's blood pressure on 9/9/20, at 10:27	s. od pressures revealed the re was documented as 76/46 p.m. re was documented as 88/54		condition changes or treatment ref Condition change will be a focus to reviewed and discussed at mornin stand-up. All nursing staff will be re-educated Change in Resident Condition Polithe Resident Weight Evaluation Polithe Resident Weight Evaluation Polithe need to notify MD timely, initial follow-up assessments, document resident treatment refusals and no supervisor for condition changes of treatment refusals. Date of Compliance: 12/4/2020 Recurrence will be prevented by: All residents with any condition changes of the condition change	d on the icy and olicy and te any tify their or	

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 7 of 17 XH1Q11

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE	
						;
		00582	B. WING		1	4/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO MN 55792	UTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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
2 830	Continued From pa	ge 7	2 830			
	- R1's blood pressure on 9/10/20, at 3:01 - No blood pressure 9/11/20, to 9/13/20 R1's blood pressure on 9/14/20, at 12:58 A progress note datindicated R1 had a physician for a "ras progress note furtheother concerns at the A document titled E Care dated 9/11/20 consultation was consultation was "rathefurther indicated R1 her blood pressures 92/72. Nursing was see if helps." R1 research	re was documented as 92/72 a.m. es were documented from re was documented as 70/40 p.m. sed 9/11/20, at 5:55 p.m. telehealth visit with her h under her left breast." The er indicated there were, "No		monthly x 2 months to assure MD notification occurred, follow-up assessments are initiated, documis present, refusals documented a supervisor notified. The results of audits will be shared with the facili Committee for input on the need to increase, decrease or discontinue audits Corrections will be monitored by: DON/Unit Managers	nentation nd these ty QAPI	
	indicated R1 was "v to stand independe R1 was unable to k questions. R1's vita pressure was "low.' and an order was o	rery lethargic" and was unable ntly "as she had been doing." eep her eyes open to answer al signs indicated her blood 'R1's physician was notified btained to send R1 to the nent. R1's daughter was				
	indicated R1's repre R1 was septic (sevents was "bad." The pro R1's representative visited with family o	ted 9/14/20, at 1:00 p.m. esentative updated the facility ere infection) and R1's urine egress note further indicated stated R1 was talkative and n 9/12/20, however, only no" questions on 9/13/20.				

Minnesota Department of Health

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	SURVEY
70001 2700	OF CONTROL OF THE CON	IDENTIFICATION NOMBER.	A. BUILDING:			
		00582	B. WING			C 94/2020
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	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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 8	2 830			
		dical record lacked indication ents were conducted from				
	conducted with lice LPN-A stated some other times she wa	p.m. an interview was nsed practical nurse (LPN)-A. etimes R1 was "clear" and sn't. LPN-A stated she did not blood pressure or change of				
	conducted with fam R1 tripped on a car (vertebrae) fracture facility. F-A stated for bedrest and the spoke to R1 on 9/1 F-A stated sometim 9/14/20, "Somethin stated she received told R1 was going t department. F-A stand looked through was unable to hang was "weak" and "lo was moaning. F-A R1's window for thr were in R1's room. registered nurse (R1's blood pressure	16 p.m. an interview was a nily member (F)-A. F-A stated opet and suffered a T11 operior to admission to the R1 was admitted to the facility rapy. F-A stated her sister 2/20, and R1 was "doing fine." ne between 9/12/20, and g happened to her [R1]." F-A d a call on 9/14/20, and was no be sent to the emergency stated she went to the facility a R1's window. F-A stated R1 g onto a phone because she oked gray." F-A stated R1 stated she stood outside of the to five minutes and no staff F-A stated she was informed the was "really low." F-A stated came to R1's room "very"				
	the hospital. F-A st physician told her F survive, and R1 loo stated she was told 50/47. F-A stated F	d she then left to meet R1 at tated once at the hospital, the R1 was not expected to ked like she was dying. F-A I R1's blood pressure was R1 had a catheter placed and ke "creamed corn." F-A stated				

Minnesota Department of Health

STATE FORM 6899 XH1Q11 If continuation sheet 9 of 17

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						;
		00582	B. WING		11/0	4/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE WATERVIEW PINES LLC 1201 8TH			STREET SO	UTH		
		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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 9	2 830			
	R1 had a lack of ox severely dehydrated	ygen to her brain and was d. F-A stated R1 had since om the hospital and was				
	conducted with LPN a lot of cares and w stated R1 "slept a loin condition for R1. report a low blood pmanager and encounter LPN-B stated she with a lot of the conducted states and states are stated she with a lot of the conducted states and states are stated she with a lot of the conducted states are stated she with a lot of the conducted states are stated she with LPN-B	p.m. an interview was N-B. LPN-B stated R1 refused was a "confused lady." LPN-B of and did not recall a change LPN-B stated she would pressure reading to her unit wrage a resident to drink fluids. would reassess a resident, who essure, every 15 minutes.				
	conducted with registated R1 was adm short-term rehabilita "very independent I her. RN-A stated coon R1, and it was d RN-A stated she wa "something was wrowas lethargic, howe "fine." RN-A stated window at this time be sent out becaus previously was. RN obtained a bed hold R1's was speaking was transferred to the daughter later calle urinary tract infection informed her R1 was un 9/13/20. RN-A stated worked on 9/13/20, seem like her "old seems with the state worked on 9/13/20, seem like her "old seems with the state worked on 9/13/20, seems like her "old seems with the state worked on 9/13/20, seems like her "old seems with the state worked on 9/13/20, seems like her "old seems with the state worked on 9/13/20, seems like her "old seems with the state worked on 9/13/20, seems like her "old seems with the state worked on 9/13/20, seems with the state worked on 9/13/20, seems like her "old seems with the state with the state worked on 9/13/20, seems with the state with	p.m., an interview was stered nurse (RN)-A. RN-A itted to the facility for ation. RN-A stated R1 was a ady" and told staff not to "bug" agnitive testing was conducted etermined R1 had dementia. as informed on 9/14/20, as informed on 9/14/20, as informed on 9/14/20, as informed on 8/14/20, as informed on 8/14/20, as informed on 8/14/20, as informed on 8/14/20, as R1's daughter was at R1's at R1's as a R1's and R1 needed to be she was not as alert as she N-A stated R1 needed to be she was not as alert as she N-A stated she left R1's room, and returned and found "gibberish." RN-A stated R1 he hospital, and R1's dand stated R1 had a "bad" on. RN-A stated R1's family as "really talkative" on 9/12/20, anable to hold a telephone on and nurse told her R1 didn't self" and R1 was "sleepier." as unable to recall who the				

Minnesota Department of Health

STATE FORM 6899 XH1Q11 If continuation sheet 10 of 17

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
					_ c	;
		00582	B. WING		11/0	4/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE WAT	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
2 830	nurse was. RN-A s remembered speak 9/11/20, and being blood pressure read frequency of blood dependent upon rearesident's blood prewould expect the chromatic RN-A stated staff "R1's blood pressure On 11/4/20, at 12:4 conducted with the The DON stated staffollow-up assessme were identified. The consultant had revidetermined staff ne pressures, and upd DON stated R1 was it was reported R1 was it was reported R1 was it was reported R1 was resident had a chromatic RN or leave a note a resident had a chromatic staff education. The facility policy C dated 6/19, directed physician/healthcar make detailed obseand pertinent inform Weights	tated she "vaguely" sing to R1's physician on told to push fluids due to low dings. RN-A stated the pressure monitoring was adings. RN-A stated if a ressure was less than 100 she harge nurse to be updated. Torobably should had followed a more closely. 5 p.m. an interview was director of nursing (DON). The were expected to conduct ents when abnormal values are DON stated a corporate rewed R1's medical record and reded to recheck R1's blood atte the medical provider. The se "good" on 9/12/20, however, was "sleepy" on 9/13/20. The nurses' were educated on and what sepsis looked like. The should not wait to talk to the for the clinical manager when ange of condition. The DON on was started on 11/3/20. The provider, the nurse will revations and gather relevant mation for the provider."	2 830			

Minnesota Department of Health STATE FORM

Minnesota Department of Health

winnesc	ita Department of He	aith				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE : COMPI	
		00582	B. WING		11/0 ₄	; 4/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO , MN 55792	UTH		
(X4) ID PREFIX TAG	(EACH 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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 11	2 830			
	identified R3 had in	nge MDS dated 8/28/20, tact cognition. R3's MDS received diuretic medication n days.				
	R3's care plan lacke were to be performed	ed indication daily weights ed.				
	directed R3 was to due to CHF. The o	ministration record (MAR) have his weight taken daily rder was discontinued on R3's MAR's from 9/1/20, to ollowing:				
	9/10/20, 9/11/20, 9/ 9/19/20/ 9/23/20, 9/ 10/14/20, 10/16/20, 10/22/20, 10/25/20, and 11/3/20. -Weights were docu	ocumented on 9/3/20, 9/6/20, 12/20, 9/13/20, 9/18/20, 26/20, 9/29/20,10/6/20, 10/17/20, 10/20/20, 10/29/20,10/30/20, 11/1/20, umented as refused on 9/5/20, 15/20 and 10/28/20.				
	conducted with R3. staff didn't forgot to didn't refuse to have	p.m. an interview was R3 stated he believed facility take his weight. R3 stated he e his weight taken as th my health is important."				
	conducted with NA- have his weight tak	p.m. an interview was B. NA-B stated R3 was to en daily. NA-B stated weights n the electronic medical				
	conducted with LPN	9 a.m. an interview was N-C. LPN-C stated R3 was to en daily, however, sometimes				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00500	B. WING		(
NAME OF		00582		274TE 7/D 00DE	11/0	4/2020
	PROVIDER OR SUPPLIER		STREET SO	STATE, ZIP CODE D UTH		
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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	On 11/4/20, at 11:19 conducted with RN-ordered to have his reviewed R3's medidocumentation of w stated there was lik was not obtained ar communicated to the unsure why weights verbalized there appoffenders" on the didocumented. RN-Erefuse having his w On 11/4/20, at 12:40 conducted with the staff were identified regarding R3's weights stated staff were exported, or document are according to the facilities to obtain an upon admission or shall be done for ear often according to the consensus between SUGGESTED MET The director of nursidevelop or revise per resident assessment physician orders. To train staff in implement in the staff in	P a.m. an interview was B. RN-B confirmed R3 was weight taken daily. RN-B deal record and confirmed reights were missing. RN-B dely instances where a weight and subsequently not he next shift. RN-B she was were not taken, however, peared to be "repeat rates in which weights were not be stated R3 was not known to reight taken. DON. The DON stated two has being "offenders" has the DON stated one ready reeducated. The DON hected to obtain weights, as hent refusals. The DON stated has a risk versus benefits	2 830			

Minnesota Department of Health

STATE FORM 6899 XH1Q11 If continuation sheet 13 of 17

winneso	<u>ita Department of He</u>	aith				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE : COMPI	
		00582	B. WING		11/ 0 /	; 4/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS CITY S	STATE, ZIP CODE		
			STREET SO			
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 SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 13	2 830			
	could perform rand compliance.	om audits to ensure				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21375	75 MN Rule 4658.0800 Subp. 1 Infection Control; Program		21375			12/4/20
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	This MN Requirement	ent is not met as evidenced				
	Based on observati review, the facility fa was completed duri	on, interview, and document ailed to ensure hand hygiene ing incontinence cares to amination for 1 of 3 residents owel and bladder		F Tag: F880 DPOC Immediate Corrective Action: NA-C was counseled and re-educa with return demonstration compete the Hand Hygiene Policy on 11/4/2	ency on 020.	
	Findings include:			Corrective Action as it applies to of All residents have the potential to be affected by the deficient practice.	ре	
		port dated 11/4/20, indicated uded dementia with nce.		facility QAPI Committee conducted Cause Analysis of the deficient pra and developed a corrective action prevent recurrence.	d a Root actice	
	10/8/20, identified F cognition. R5's MD totally dependent u	num Data Set (MDS) dated R5 had severely impaired S further identified she was pon staff for toileting, and was of bowel and bladder.		The Policy and Procedure for prop Hygiene was reviewed and remain current with CDC guidelines. All staff to include the DON and Int Preventionist will receive re-educa the Hand Hygiene Policy and Proc	s fection tion on	
	experienced bowel	d 7/12/20, indicated R5 and bladder incontinence. The staff to provide incontinence		Transmission based precautions a caring for and disinfecting medical equipment. Resources from CDC		

Minnesota Department of Health STATE FORM

	Minnesota Department of Health		ealth			1 Ordivi7	WITHOULD
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC 1201 8TH STREET SOUTH VIRGINIA, MN 55792 Continued From page 14 Care after each incontinence product in a partiage can. NA-C states for a side rail. NA-C pushed on RS's back and rolled RS hat old for solled incontinence product to wipe stool off of RS's bluttoxs. NA-C then partially rolled R5's solled incontinence product and putified incontinence product to wipe stool off of RS's buttoxs. NA-C then partially rolled R5's solled incontinence product to wipe stool off of RS's buttoxs. NA-C then partially rolled R5's solled incontinence product to wipe stool off of R5's buttoxs. NA-C then partially rolled R5's solled incontinence product the solled incontinence product to wipe stool off of R5's buttoxs. And partially placed it under R5. NA-C bushined a delional partially placed it under R5. NA-C bushined a delional partially placed it under R5. NA-C bushined a delional partially placed it under R5. NA-C bushined a delional partially placed it under R5. NA-C bushined a dean incontinence product which was on R3's bed. NA-C disposed of the solled incontinence product which was on R5's buttoxs, and placed each wet wipe on the solled incontinence product which was on R5's buttoxs. And partially placed it under R5. NA-C bushined a dean incontinence product which was on R5's buttoxs. And partially placed it under R5. NA-C bushined a dean incontinence product which was on R5's buttoxs. And placed each wet wipe on the solled incontinence product which was on R5's buttox was on R5's gift hand with her solled gloved hand. NA-C validated to R5's left side and assisted R5 roll to her right side by pushing on her back with her solled gloved hands. NA-C was an advanced to R5's left side and assisted R5's lute was an advanced to R5's	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, ,			
August Continued From page 14 Care after each incontinence product NA-C grabbed wet wipes, cleaned R5's solled incontinence product to wipe stool off of R5's butlocks. NA-C transfer the product of the partially polaced in continuence product which was on R5's bed. NA-C obtained a clean incontinence product and partially placed it under R5. NA-C stated a clean incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed in under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence product and partially placed it under R5. NA-C incontinence pro			00582	B. WING			
CALC DESTINATION CALC COMPACTIVE ACTION SHOULD BE CROSS-REFERRED ALAND OF CORRECTION COMPACTIVE ACTION SHOULD BE CROSS-REFERRED ALAND OF CORRECTIVE ACTION SHOULD BE CROSS-REFERRED ALAND SHOULD BE CROSS-REFERRED SHOULD SHOULD BE CROSS-REFERRED ALAND SHOULD BE CROSS-REFERRED SHOULD SHOULD BE CROSS-REFERRED ALAND SHOULD BE CROSS-REFER	NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR USE (DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR USE (DENTIFYING INFORMATION) 21375 Continued From page 14 care after each incontinent episode. On 11/4/20, at 10:39 a.m. nursing assistant (INA)-C entered R5's room, provided privacy, and put on a pair of gloves. NA-C transferred R5 from a wheelchair to a bed, using a mechanical ceiling lift. NA-C lowered R5's pants and unfastened R5's solided incontinence product. NA-C grabbed wet wipes, cleaned R5's solided incontinence product R5 to reach for a side rail. NA-C publed R5 to her left side. NA-C used an exposed portion of R5's back and rolled R5 to her left side. NA-C used an exposed portion of R5's solied incontinence product, then partially rolled R5's solied incontinence product, then partially rolled R5's solied incontinence product, then partially rolled R5's solied incontinence product, and pulled it out from under R5. The solied incontinence product many aparage. Without changing gloves or performing hand hygiene, NA-C obtained additional wet wipes, cleaned R5's blue sweater near R5's right shoulder, and briefly held R5's right hand with her soiled gloved hands. NA-C pulled the clean incontinence product from under R5, and pulled down R5's blue sweater with her soiled gloved hands. R5 again rolled to her back, NA-C reached for the package of wet wipes and stated, "I would like another pair of gloves." NA-C	THE WAT	FEDVIEW DINES LLC	1201 8TH	STREET SC	ОИТН		
21375 Continued From page 14 care after each incontinent episode. On 11/4/20, at 10:39 a.m. nursing assistant (NA)-C entered R5's room, provided privacy, and put on a pair of gloves. NA-C transferred R5 from a wheelchair to a bed, using a mechanical ceiling lift. NA-C lowered R5's pants and unfastened R5's soiled incontinence product. NA-C grabbed wet wipes, cleaned R5's groin area, and disposed of the wet wipes in a garbage can. NA-C stated R5 was "wet," and encouraged R5 to reach for a side rail. NA-C pushed on R5's back and rolled R5 to her left side. NA-C used an exposed portion of R5's solied incontinence product to wipe stool off of R5's buttocks. NA-C then partially rolled R5's solied incontinence product, and pulled it out from under R5. The solied incontinence product remained on R5's bed. NA-C disposed of the solied incontinence product and partially placed it under R5. NA-C instructed R5 to roll on her back and R5 let go of the bed rail. NA-C touched R5's bight hand with her soiled gloved hands. NA-C pulled the clean incontinence product from under R5, and pulled down R5's blus sweater near R5's right shoulder, and briefly held R5's right hand with her soiled gloved hands. R5 again rolled to her back. NA-C reached for the package of wet wipes and stated, "I would like another pair of gloves." NA-C	THE WAI	ERVIEW FINES LLC	VIRGINIA,	, MN 55792			
care after each incontinent episode. On 11/4/20, at 10:39 a.m. nursing assistant (NA)-C entered R5's room, provided privacy, and put on a pair of gloves. NA-C transferred R5 from a wheelchair to a bed, using a mechanical ceiling lift. NA-C lowered R5's pants and unfastened R5's soiled incontinence product. NA-C grabbed wet wipes, cleaned R5's groin area, and disposed of the wet wipes in a garbage can. NA-C stated R5 was "wet," and encouraged R5 to reach for a side rail. NA-C pushed on R5's back and rolled R5 to her left side. NA-C used an exposed portion of R5's soiled incontinence product to wipe stool off of R5's buttocks. NA-C then partially rolled R5's osiled incontinence product remained on R5's bed. NA-C obtained additional wet wipes, cleaned R5's buttocks, and placed each wet wipe on the soiled incontinence product which was on R5's bed. NA-C disposed of the soiled incontinence product which was on R5's bed. NA-C obtained additional wet wipes, cleaned R5's buttocks, and placed each wet wipe on the soiled incontinence product which was on R5's bed. NA-C obtained additional wet wipes, cleaned R5's buttocks, and placed each wet wipe on the soiled incontinence product which was on R5's bed. NA-C obtained additional wet wipes, cleaned R5's buttocks, and placed each wet wipe on the soiled incontinence product which was on R5's bed. NA-C balked to R5's left side and partially placed it under R5. NA-C instructed R5 to roll on her back and R5 let go of the bed rail. NA-C touched R5's blue sweater near R5's right shoulder, and briefly held R5's right hand with her soiled gloved hands. NA-C pulled the clean incontinence product from under R5, and pulled down R5's blue sweater with her soiled gloved hands. R5 again rolled to her back. NA-C reached for the package of wet wipes and stated, "I would like another pair of gloves." NA-C	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	(X5) COMPLETE DATE
On 11/4/20, at 10:39 a.m. nursing assistant (NA)-C entered R5's room, provided privacy, and put on a pair of gloves. NA-C transferred R5 from a wheelchair to a bed, using a mechanical ceiling lift. NA-C lowered R5's pants and unfastened R5's soiled incontinence product. NA-C grabbed wet wipes, cleaned R5's groin area, and disposed of the wet wipes in a garbage can. NA-C stated R5 was "wet," and encouraged R5 to reach for a side rail. NA-C pulled the volume results of the auditional wet wipes or the soiled incontinence product to wipe stool off of R5's butcoks. NA-C then partially rolled R5's soiled incontinence product, and pulled it out from under R5. The soiled incontinence product additional wet wipes, cleaned R5's buttooks, and placed each wet wipe on the soiled incontinence product which was on R5's bed. NA-C disposed of the soiled incontinence product a garbage. Without changing gloves or performing hand hygiene, NA-C obtained a clean incontinence product and partially placed it under R5. NA-C instructed R5 to roll on her back and R5 let go of the bed rail. NA-C touched R5's blue sweater near R5's right shoulder, and briefly held R5's right hand with her soiled gloved hands. NA-C pulled the clean incontinence product from under R5, and pulled down R5's blue sweater with her soiled gloved hands. R5 again rolled to her back. NA-C reached for the package of wet wipes and stated, "I would like another pair of gloves." NA-C	21375	Continued From pa	ige 14	21375			
gloves. R5 grabbed additional wet wipes and wiped R5's inner thighs. NA-C started to fasten	213/3	care after each incomon 11/4/20, at 10:3 (NA)-C entered R5' put on a pair of glow from a wheelchair to ceiling lift. NA-C low unfastened R5's so NA-C grabbed wet area, and disposed can. NA-C stated R5 to reach for a si back and rolled R5 exposed portion of product to wipe stothen partially rolled product, and pulled soiled incontinence bed. NA-C obtained cleaned R5's buttoon the soiled incomon R5's bed. NA-C disincontinence product changing gloves or NA-C obtained a cleaned R5's buttoon the soiled incomon R5's bed. NA-C disincontinence product changing gloves or NA-C obtained a cleaned R5's buttoon her back at the pulled the clean incomon R5, and pulled dow soiled gloved hand and assisted R5 roll on her back with her pulled the clean incomon R5, and pulled dow soiled gloved hand and assisted R5 roll on her back with her pulled the clean incomon R5, and pulled dow soiled gloved hands NA-C reached for the stated, "I would like did not perform har gloves. R5 grabber	ontinent episode. 9 a.m. nursing assistant I's room, provided privacy, and I's room, provided privacy, and I's room, provided privacy, and I'ves. NA-C transferred R5 It o a bed, using a mechanical I wered R5's pants and I wered R5's groin I of the wet wipes in a garbage I was "wet," and encouraged I wet encouraged I wet wipes in a garbage I was "wet," and encouraged I was a land encourage I was a land enco		The DON, Infection Preventionist a Clinical Education Coordinator will return demonstration competencie proper hand hygiene with all staff a maintain a log with results. Date of Compliance: 12/4/2020 Recurrence will be prevented by: The DON, Infection Preventionist a other leadership staff will conduct on all shifts, every day for one were assure proper infection control pra are being followed including hand The results of the audits will be sh with the facility QAPI Committee a based on the results, the audits with continue daily or decrease in number discontinued once 100% compidemonstrated. Corrections will be monitored by:	and conduct es on and and audits ek to actices hygiene. ared nd II bers and	

Minnesota Department of Health

winnesc	ita Department of He	eaith .				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					c	
		00582	B. WING			4/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DESS CITY S	STATE, ZIP CODE	•	
INAIVIE OF I	-ROVIDER OR SUPPLIER					
THE WA	TERVIEW PINES LLC		STREET SO	UTH		
			MN 55792			
(X4) ID PREFIX	_	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	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)		
21375	Continued From pa	ge 15	21375			
	R5's incontinence r	product. At 10:52 a.m. the				
		(DON) entered R5's room.				
		d NA-C to remove her gloves,				
		nd to put clean gloves on.				
		's bathroom, washed her				
		d to R5 with additional pairs of				
		d, "I should have done this in				
		-C finished fastening R5's				
		ct, and R5 was rolled				
		r pants were raised. The DON remove her gloves and again				
	wash her hands.	remove her gloves and again				
	wash her hands.					
	On 11/4/20, at 11:0	7 a.m. an interview was				
		stered nurse (RN)-B. RN-B				
		e needed to be completed				
	,	continence cares. RN-B stated				
		contamination if staff failed to				
	perform hand hygie	ene.				
	On 11/4/20, at 11:2:	2 a.m. an interview was				
		-C. NA-C confirmed she				
		hand hygiene and put on new				
		rformed incontinence cares on				
	R5. NA-C stated sl	ne was "nervous."				
		_				
		5 p.m. an interview was				
		DON. The DON stated staff				
	•	rash their hands and change noving from a dirty area to a				
		esident care. The DON stated				
	it was an infection of					
		and Hygiene dated 6/17,				
		ene needed to be completed,				
		a resident's mucous				
	membranes and bo	dy fluids or excretions."				
	SUGGESTED MET	HOD OF CORRECTION:				
		sing (DON), or designee, could				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00582	B. WING) 4/2020
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 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
21375	educate all appropr hand hygiene needs or designee, could on the policies and designee, could dev ensure ongoing cor	iate staff on indications when s to be performed. The DON, educate all appropriate staff procedures. The DON, or velop monitoring systems to	21375			

Minnesota Department of Health

STATE FORM 6899 XH1Q11 If continuation sheet 17 of 17