

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered February 8, 2022

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

RE: CCN: 245283

Cycle Start Date: February 7, 2022

Dear Administrator:

On February 7, 2022, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

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 January 18, 2022

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

RE: CCN: 245283

Cycle Start Date: January 7, 2022

#### Dear Administrator:

On January 7, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

### DEPARTMENT CONTACT

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

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

Mobile: (218) 368-4467

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by April 7, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 7, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health

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: 01/28/2022 FORM APPROVED OMB NO. 0938-0391

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 1201 8TH STREET SOUTH VIRGINIA, MN 55792	P CODE	<u> </u>	·
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F 000	survey was conduct was found to be No requirements of 42 Requirements for L. The following compsuBSTANTIATED: H5283039C (MN79F550, F677, F725H5283040C (MN79F550, F677, F725H52840C (MN79F50, F677, F725H52840C	2, a standard abbreviated sted at your facility. Your facility. The compliance with the CFR 483, Subpart B, and Term Care Facilities.  Delaints were found to be compliance cited at the compliance upon the compliance upon the compliance upon the compliance is not required the first page of the CMS-2567 in submission of the POC will tion of compliance.  Cacceptable electronic POC, and are facility may be conducted to compliance with the compliance with the compliance.  Cacceptable electronic POC, and are facility may be conducted to compliance with the compliance of Rights 1)(2)(b)(1)(2)	F 0			2	2/2/22
LABORATOR)	/ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X	(6) DATE

Electronically Signed 01/26/2022

v deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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F 550	promotes maintenather quality of life, reindividuality. The fapromote the rights  §483.10(a)(2) The access to quality caseverity of condition must establish and practices regarding provision of service residents regardles  §483.10(b) Exercise The resident has the rights as a resident or resident of the US  §483.10(b)(1) The resident can exercise interference, coercifrom the facility.  §483.10(b)(2) The free of interference reprisal from the farights and to be supexercise of his or his subpart.  This REQUIREMED by:  Based on observative review the facility fawere continent of be needs met to prevent associated embarration (R1, R8), in additional control of the continent of be needs met to prevent associated embarration.	ance or enhancement of his or ecognizing each resident's acility must protect and of the resident.  facility must provide equal are regardless of diagnosis, in, or payment source. A facility maintain identical policies and it transfer, discharge, and the es under the State plan for all es of payment source.  The of Rights is of the facility and as a citizent and it is of the facility and as a citizent and it is of the facility and as a citizent and it is or her rights without it is, discrimination, or reprisal are resident has the right to be and cility in exercising his or her poported by the facility in the er rights as required under this in the resident as required under this in the resident and document alled to ensure residents who sowel and bladder had their ent bladder accidents and assment for 2 of 7 residents in preferences for bedtime of 7 residents (R8), reviewed	F 5	F550 Resident Rig Immediate Correcti Resident 1 had her ADLs provided per Resident 8's call lig	brief changed and	S	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		245283	B. WING _			07/2022	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
THE WA	TERVIEW PINES LLC			1201 8TH STREET SOUTH			
				VIRGINIA, MN 55792			
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F 550	Findings include: R1's Face Sheet dastage IV kidney dis R1's quarterly Minin 12/21/20, indicated had mild depressio with toileting with o R1 was typically co and that incontinen dignity. On 1/6/22, at 9:10 a sitting in a soiled by which was a hospit staff at 7:30 a.m., vrounds, that she was then reported it aga 8:50 a.m. when her R1 indicated she to in bed in a wet bried up in the morning, wher chair before broreported she could bathroom and tried urgency so staff ne	ated 1/7/22, indicated R1 had ease and rheumatoid arthritis.  mum Data Set (MDS) dated R1 was cognitively intact and n. R1's MDS indicated assist ccasional incontinence, that ntinent of bowel and bladder ce had the potential to impact a.m., R1 indicated she was rief. R1 pointed to her clothing, al gown. R1 reported she told when they made morning as sitting in a soiled brief. She ain to activity aide (AA)-A at breakfast tray was delivered. Indicated she liked to get get cleaned up, dressed and in eakfast was served. R1 tell when she had to use the to wait. R1 stated she had eded to come when she she did not like going in her	F 55	DEFICIENCY)	to others: icy was as reviewed as will be eferences ed on ang call lights ing resident  by: completed to re being met of for 2 dits will be committee se, iudit.		
	and another staff m towels and a clean R1 was observed s eating breakfast.	a.m., nursing assistant (NA)-A nember entered R1's room with brief. On 1/6/22, at 9:38 a.m., itting in her chair, dressed and					
		nev need to use the restroom					

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F 550	she would put call is she left the room, to she turned R1's cal room at 8:50 a.m. to On 1/6/22, from 8:1 light for R1 was not On 1/6/22, at 11:19 knew R1 was soiled reported by AA-A. Nowas reported to her was aware that sitti extended time could	ight on for resident and when ell staff. AA-A could not recall if I light on when she left the hat morning.  5 a.m., to 9:30 a.m., the call activated.  a.m., NA-A reported she dat 8:30 a.m., when it was NA-A could not remember if it rearlier. NA-A reported she ng in a soiled brief for	F 55	50		
	R8's Admission Recindicated R8's diagrobesity, low back prodepression.  R8's annual Minimum 11/24/21, indicated no rejections of car required extensive R8's MDS indicated episodes of bladder one episode of contraction on the contraction of t	and getting cleaned when is a dignity concern.  cord printed on 1/7/22, noses included morbid ain, anxiety disorder, and important process. In addition, R8 assistance of one for ADLs. If she had seven or more incontinence, but had at least tinence.  Indicated R8 had bility related to weakness and ance of one for toileting.				

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F 550	On 1/6/22, at 10:29 (LPN)-A stated staff needs of the reside were not getting do repositioning every were up in chairs t Specifically, LPN-A and changes and retimely.  On 1/6/22, at 3:38 pstated she was lateready for bed becarstaff.  On 1/6/22, at 3:49 pherself daily becausight. R8 stated this "today". R8 was tea embarrassed and swait longer than shready for bed becarbar.  On 1/7/22, at 9:50 a (DON) verified if a pstate and according to the concern for dignity, resident's request for respected and according to the concern for dignity. The facility policy time to the concern for dignity. The pstate and the concern for dignity of individuality. The pstate and the concern for dignity of individuality as maintaining the concern for dignity as maintaining the concern for dignity as maintaining the concern for dignity of individuality. The pstate is the concern for dignity of individuality as maintaining the concern for dignity and the concern for dignity as maintaining the concern for dignity and the concern for dignity as maintaining the concern for dignity and the concern	a.m. licensed practical nurse f were not able to meet the ints. LPN-A stated showers ne, check and changes, two hours, and once residents hey would stay up. stated on 1/5/22, the check epositioning were not done on incomparison of the interest of the int	F 55			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	G()	C C	
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F 677	toileting assistance The facility policy tit December 2016, id include self-determ existence. ADL Care Provided	promptly to requests for  tle Resident Rights revised entified resident rights to ination and a dignified  for Dependent Residents	F 55		2/2/22
SS=E	out activities of dail services to maintain personal and oral harmonic personal harm	sident who is unable to carry y living receives the necessary of good nutrition, grooming, and ygiene; NT is not met as evidenced of and document review the ure residents had their ing (ADLs) completed for 5 of of of the complete for 5 of of of the complete for 5 of of of the complete for 5 of of the complete for 5 of the complete fo		F677 ADL Care Provided for Dependence Residents  Immediate Corrective Action: Resident #1, 7, 8, 9 and 10's care newere addressed. Corrective Action as it applies to other The Activities of Daily Living, Support policy was reviewed and remains curtail resident care sheets were update reflect current needs for ADLs. All nursing staff will be educated on following resident care plan for ADL rand documenting ADLs during or at their shift.  Date of Compliance: 02/02/2022  Recurrence will be prevented by: Audits of 5 residents to ensure individualized care sheets are being	eeds ers: ting erent. d to

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 677	oral cares.  The nurse assistant undated, indicated hours, a total assistance a ceiling lift for R1's documentation last four weeks were On 1/6/22, at 9:10 a broke on evening sfixed this morning, be used due to a property of all the issues. Recleaned up, dresse eating breakfast.  On 1/6/22, at 9:10 a bed in a hospital gotthe room.  On 1/6/22, at 11:19 confirmed R1's ceil shift and it was not NA-A confirmed Hours of the room are but had not gotten and some personner.  On 1/6/22, at 10:29 (LPN)-A stated on cares but had not gotten and some personner.	t daily assignment sheet R1 was to be turned every two to one for transfers and to mobility.  In of cares and outputsfor the re requested but not provided.  In a.m., R1 stated the ceiling lift hift last night and maintenance R1 stated the Hoyer could not rior concern. R1 stated she f and hospital gown because I stated she liked to get d and up in her chair prior to a.m., R1 was observed in her own; there was urine odor in  In a.m., nurse assistant (NA)-A ing lift had broken on a prior fixed until this a.m., shift. Over lift cannot be used on R1.  In a.m. licensed practical nurse a.m. licensed practi	F 677	followed weekly x4 weeks months to ensure that they the level of assist for ADL oneed. The results of the aushared with the facility QAI for input on the need to incidecrease, or discontinue the Corrections will be monitor Director of Nursing/ Design	vare receiving care that they udits will be PI committee crease, ne audit.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 677	11/4/21, indicated limpaired and demosymptoms one to textensive assistant activities of daily livoccasionally inconference of the self-care deficit relacion of the cognitive impairmed required assistance body dressing. In addirected staff to as two hours and as mincontinence care of R7's care plan indicassistance of one of grooming.  R7's documentation past four weeks we R7 was not intervier reasonable person want to lie in bed under the company of the	mum Data Set (MDS) dated R7 was severely cognitively onstrated physical behavioral hree days. R7 required ce to total dependence for ving. In addition, R7 was tinent of bladder.  ed 8/8/19, indicated R7 had a sated to hemiplegia and ent. R7's care plan indicated R7 e of one for upper and lower addition, R7's care plan sess R7 for incontinence every needed and to provide with each incontinent episode. Cated R7 required the for bathing, dressing, and  n of cares and output for the ere requested but not provided.	F6	377			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
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F 677	R8's MDS indicated episodes of bladde one episode of con R8's care plan date an alteration in mol required the assistant R8's output record four weeks. The farecords of intake an On 1/6/22, at 3:38 stated on 1/5/22, sl providing bedtime of was not enough stated on 1/6/22, at 3:49 herself daily because light. R8 stated this "today". R8 was teat embarrassed and swait longer than sh	d she had seven or more r incontinence, but had at least tinence.  ed 11/24/20, indicated R8 had bility related to weakness and ance of one for toileting.  was requested for the past cility was unable to provide nd output.  p.m. nursing assistant (NA)-B he was late two hours or more cares for R8 because there	F 6	77		
	R9 had diagnoses R9's quarterly MDS was severely cogni extensive to total d	cord printed 1/7/22, identified which included dementia.  6 dated 10/8/21, indicated R9 tively impaired, required ependence with ADLs, and nent of bowel and bladder.				
	incontinent of bowe assessment of elim	ed 7/12/19, indicated R9 was el and bladder and required an nination needs every two hours eare after incontinent episodes.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION  NG		COMPLETED		
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F 677	In addition R9's car limited in her ability ADLs. Staff were di cares, washing of hand extensive assis R9's documentation weeks was request R10's Admission Rindicated R10's dia dementia, anxiety, depression.  R10's quarterly MD R10 had adequate understand and be was cognitively intarejection of cares. If dependence for AD as always incontine R10's care plan datassess for incontine needed/requested with each incontine R10's output record four weeks. The factor of this.  On 1/6/22, at 3:38 pto bed at 7 p.m. becould help her. R10	e plan indicated R9 was to independently carry out rected to assist with oral ands and face with cueing st of one for all other ADLs.  n of cares for the past four ed but not provided.  ecord printed on 1/7/22, gnoses included hemiplegia, Alzheimer's disease, and  S dated 11/5/21, indicated hearing and was able to understood. In addition, R10 ct, had no behaviors or R10 required extensive to total Ls. R10's MDS identified her ent of bladder.  sed 9/5/19, directed staff to ence every two hours and as and provide incontinent cares	F 6	77			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COM	E SURVEY  IPLETED
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(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 APPROPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 677	On 1/6/22, at 3:58 p stated she was two for R9 and R10, be help. NA-B stated s with the help of a no to provide medication residents.  On 1/7/22, at 9:50 at (DON) verified one expected to complet two hour reposition timely for 23 reside	o.m. nursing assistant (NA)-B hours late with bedtime cares cause there was not enough he was caring for 23 residents urse who had responsibilities ons and treatments for the 23 a.m. the director of nursing NA would not reasonably be the check and changes, everying, and answering call lights ints. The DON also verified she	F 677			
	residents did not have residents did not have (ADLs), Supporting residents who were of daily living indeposervices necessary personal and oral histaff would provide for residents unable independently, with and in accordance Treatment/Svcs to CFR(s): 483.25(b)(1) Skin Intelligence States (Section 1) Press Based on the compresident, the facility	the consent of the resident with the plan of care. Prevent/Heal Pressure Ulcer 1)(i)(ii) egrity sure ulcers. rehensive assessment of a must ensure that-	F 686			2/2/22
	professional standa pressure ulcers and ulcers unless the in	es care, consistent with ords of practice, to prevent d does not develop pressure dividual's clinical condition hey were unavoidable; and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245283	B. WING		01/07/2022	
	PROVIDER OR SUPPLIER TERVIEW PINES LLC			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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE	TION
F 686	(ii) A resident with processary treatmer with professional st promote healing, promote healing, promote healing, promote healing, procession of the second review the facility for review the facility for reviewed for repositioned timely reviewed deep tissue chronic peripheral of functioning of the viewelling and skin cl.  R2's annual Minimut 11/30/21, indicated required extensive daily living (ADLs), incontinent of bladdincontinence episod continence. In additioned the assistate addition, R2 required wheelchair to toilet.  R2's neighborhood	pressure ulcers receives and and services, consistent and services, consistent and ards of practice, to revent infection and prevent veloping.  NT is not met as evidenced alled to ensure a resident was for 1 of 1 residents (R2) tioning.  Cord printed 1/7/22, indicated which included pressure e damage of left heel, and venous insufficiency (improper ein valves in the legs causing hanges).  Im Data Set (MDS) dated R2 was cognitively intact, assistance with activities of and was occasionally der with seven or more des but at least one episode of tion, R2 was at risk for skin and the assistance of one from ed the assistance of one from	F 686	F686 Treatment/ Svcs to Prevent/H Pressure Ulcer  Immediate Corrective Action: Resident 2's repositioning needs we addressed.  Corrective Action as it applies to oth The Repositioning policy was review and updated with current information All resident care sheets were update reflect current needs for repositionin All nursing staff were re-educated on need to reposition residents per their individualized needs based on their sheets.  Date of Compliance: 02/02/2022  Recurrence will be prevented by: Audits of 5 residents who need to be repositioned will be completed week weeks then monthly for 2 months to ensure that they are being reposition per their individualized care needs. results of the audits will be shared we facility QAPI committee for input on need to increase, decrease, or discontinue the audit  Corrections will be monitored by:	ers: ved n. ed to ng. n r care	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED	
		245283	B. WING_			C <b>/07/2022</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		0112022	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 686	observation from 8: assisted with morni into her wheelchairat 10:51 a.m. R2 wheelchair with her -at 11:10 a staff me bathroom per R2's chair.  On 1/6/22, at 11:38 verified he was not timely, stating "too I NAs on the day shif with check and charesidents.  On 1/7/22, at 9:50 a	a.m. during a continuous 20 a.m. to 11:20 a.m. R2 was ng cares and then assisted	F 68	Director of Nursing/ Designee			
	reposition residents are not able to do the ask for help.  The facility policy tit 2013, indicated the was to prevent skin circulation and provesidents. The policial chair should be or repositioning schedus Sufficient Nursing SCFR(s): 483.35(a) (S483.35(a) Sufficient The facility must have appropriate comprovide nursing and	s every two hours and if they his she would expect them to ded Repositioning revised May purpose of repositioning to breakdown, promote wide pressure relief for ey directed resident who are in an every one hour ule.  Staff 1)(2)	F 72	25		2/2/22	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245283	B. WING				) 07/2022
	PROVIDER OR SUPPLIER			12	TREET ADDRESS, CITY, STATE, ZIP CODE 201 8TH STREET SOUTH IRGINIA, MN 55792	• • • • • • • • • • • • • • • • • • • •	=
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	well-being of each resident assessme and considering the diagnoses of the fa accordance with that §483.70(e).  §483.35(a)(1) The by sufficient number types of personnel nursing care to all resident care plans (i) Except when was this section, licensed (ii) Other nursing polimited to nurse aid §483.35(a)(2) Except paragraph (e) of the designate a licensed nurse on each tour This REQUIREMED by:  Based on observations	I, mental, and psychosocial resident, as determined by ints and individual plans of care in number, acuity and cility's resident population in the facility assessment required afacility must provide services are of each of the following on a 24-hour basis to provide residents in accordance with the initial including but not each of the facility must be the facility must are to serve as a charge	F 7	725	F725 Sufficient Nursing Staff		
	staffing was available for 4 of 7 residents repositioning for 1 or resident preferred to preference for 3 of This practice had the residents who residents	ole to provide timely toileting (R1, R8, R9 and R10); timely of 1 residents (R2), and wake or bedtimes per 7 residents (R7, R9, R10). The potential to affect all le in the facility and require			Immediate Corrective Action: Resident #1, 2, 7, 8, 9 and 10's nee were addressed.  Corrective Action as it applies to oth The Staffing policy was reviewed an remains current.	ners: nd	
	assistance with car Findings include: TOILETING	es.			All current residents' care plans will reviewed to ensure toileting preferer are updated. All nursing staff will be educated on resident preferences, answering cal in a timely manner, and following re	nces Il lights	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245283	B. WING	·····	01/0	; 7/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
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F 725	R1's Face Sheet distage IV kidney dis R1's quarterly Minit 12/21/20, indicated had mild depression with toileting with orindicated typically orindicated by which was a hospit staff at 7:30 a.m. a hospital gown when R1 stated she then aide (AA)-A at 8:50 was delivered. R1 she did not want to indicated she liked cleaned up, dressed breakfast was serve when she had to us wait. R1 stated she to come when she like going in her brido. R1 stated she is left on commode for staffing.  On 1/6/22, at 11:00 knew R1 was soile	age 14 ated 1/7/22, indicated R1 had ease and rheumatoid arthritis.  mum Data Set (MDS) dated R1 was cognitively intact and In. R1's MDS indicated assist ccasional incontinence. MDS continent of bowel and bladder. The potential to impact dignity.  a.m., R1 indicated she was rief. R1 pointed to her clothing, all gown. R1 reported she told about her soiled brief and in they made morning rounds. The reported it again to activity a.m. when her breakfast tray indicated she told AA-A that the eat in bed in a wet brief. R1 to get up in the morning, get and in her chair before red. R1 reported she could tell se the bathroom and tried to the had urgency so staff needed called. She stated she did not ref but didn't know what else to the had urgency so staff needed called. She stated she did not ref but didn't know what else to the had urgency so staff needed called. She stated she did not ref but didn't know what else to the had urgency so staff needed called. She stated she did not ref but didn't know what else to the had urgency so staff needed called. She stated she did not ref but didn't know what else to the had urgency so staff needed called. She stated she did not ref but didn't know what else to the had urgency so staff needed called. She stated she did not ref but didn't know what else to the had urgency so staff needed called. She stated she did not refer but didn't know what else to the had urgency so staff needed called. She stated she did not refer but didn't know what else to the had urgency so staff needed called. She stated she did not refer but didn't know what else to the had urgency so staff needed called. She stated she did not refer but didn't know what else to the had urgency so staff needed called. She stated she did not refer but didn't know what else to the had urgency so staff needed called. She stated she did not refer but didn't know what else to the had urgency so staff needed called. She stated she did not refer but didn't know what else to the had urgency so staff needed called she had urge	F 725	,	on DL needs at end of ated to ning. on neir eir care nly ents are leted to eing met 2 will be mittee t. ng onthly x 2 ceiving	
	was reported to he many of the reside because of staffing several times wher quickly enough to g	r earlier. NA-A reported that nts' cares are "way behind"  j. She stated there were not they could not get to them get residents on the commode.		need. The results of the audits will shared with the facility QAPI common for input on the need to increase, decrease, or discontinue the audit Audits of 5 residents who need to repositioned will be completed we	mittee t. be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	СОМ	E SURVEY PLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1201 8TH STREET SOUTH VIRGINIA, MN 55792		0112022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 725	R8's Admission Reindicated R8's diag obesity, low back p depression.  R8's annual Minimum 11/24/21, indicated no rejections of car required extensive R8's MDS indicated episodes of bladde one episode of con R8's care plan date an alteration in mobine required the assistation R8's output record four weeks. The fact records of intake an On 1/6/22, at 3:49 pherself daily because to answer her call lial ready had three and 1/6/22. R8 states her weekly shower enough staff. In adto wait longer than	cord printed on 1/7/22, noses included morbid ain, anxiety disorder, and um Data Set (MDS) dated R8 was cognitively intact, had e or behaviors. In addition R8 assistance of one for ADLs. It is she had seven or more r incontinence, but had at least tinence.  In d 11/24/20, indicated R8 had bility related to weakness and ance of one for toileting.  In was requested for the past cility was unable to provide	F 725	weeks then monthly for 2 is ensure that they are being per their individualized car results of the audits will be facility QAPI committee for need to increase, decreas discontinue the audit  Corrections will be monitor Director of Nursing/ Design	repositioned e needs. The e shared with the r input on the e, or red by:	
	PREFERENCES					
		cord printed 1/7/22, indicated which included pressure				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF		243203	D. WING		OTREET ARRESTS OFFICE AIR CORE	01/	07/2022
	PROVIDER OR SUPPLIER  TERVIEW PINES LLC			1	STREET ADDRESS, CITY, STATE, ZIP CODE  201 8TH STREET SOUTH  //IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	) BE	(X5) COMPLETION DATE
F 725	induced deep tissuchronic peripheral of functioning of the viswelling and skin of R2's annual Minimum 11/30/21, indicated required extensive daily living (ADLs), incontinent of bladdincontinence episocontinence. In addibreakdown.  R2's care plan date required the assistant addition R2 required wheelchair to toilet.  R2's neighborhood indicated R2 require wheelchair to toilet.  R2's neighborhood indicated R2 require wheelchair to be a are so busy. R2 stancidents in her brianswer her call light facility didn't have of the control of the contr	e damage of left heel, and venous insufficiency (improper ein valves in the legs causing hanges).  um Data Set (MDS) dated R2 was cognitively intact, assistance with activities of and was occasionally der with seven or more des but at least one episode of tion R2 was at risk for skin ed 12/24/20, indicated R2 ance of one for all transfers. In the date assistance of one from resident list printed 1/6/22, ed repositioning every two p.m. R2 stated her call light answered because the staff don't at fast enough. R2 stated the	F	725			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245283	B. WING			<i>,</i> 17/2022
	PROVIDER OR SUPPLIER  TERVIEW PINES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 725	(A)-B was observed bathroom in R2's roon 1/6/22, at 11:38 able to reposition R "behind". NA-C stat working and there is On 1/6/22, at 2:12 R2 to the bathroom wheelchair to the towheelchair because there wasn't any state TOILEING AND PR R7's Admission Rediagnoses which in (paralysis of one signon-dominant side, wasting and atroph R7's quarterly Minimal Marchael Property of the extensive assistance activities of daily livoccasionally incont R7's care plan dates self-care deficit relacognitive impairmer required assistance body dressing. In a directed staff to assistance of the extensive staff to assistance body dressing. In a directed staff to assistance body dressing. In a directed staff to assistance body dressing. In a directed staff to assistance of the extensive assistance body dressing. In a directed staff to assistance body dressing. In a directed staff to assistance of the extensive assistance body dressing. In a directed staff to assistance of the extensive assistance body dressing. In a directed staff to assistance of the extensive assistance body dressing. In a directed staff to assistance of the extensive assistance body dressing. In a directed staff to assistance of the extensive assistance body dressing.	d bringing R2 out of the com.  a.m. NA-C stated he was not the com.  a.m. NA-C stated he was not the come that there were only 2\two NAs should be three.  b.m. A-B stated she brought the complete and back again to her complete and back again to her complete and the complete and	F 725			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG	COV	COMPLETED	
		245283	B. WING _		l l	/07/2022	
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F 725	R7's care plan indicassistance of one figrooming. R7's documentatio requested for the pwas unable to provand output or chec	cated R7 required the for bathing, dressing, and n of cares and output were east four weeks. The facility ide documentation of intake	F 72	25			
	(LPN)-A stated state cares and get R7 u 1/5/22. On 1/6/22, at 11:38	a.m. licensed practical nurse ff were not able to do morning up for the day until noon on a.m. NA-C stated he was not before noon on 1/5/22, because ugh staff.					
	R9 had diagnoses R9's quarterly MDS was severely cogni extensive to total d was always inconti R9's care plan date incontinent of bowe assessment of elim with incontinence of In addition R9's car limited in her ability ADLs. Staff were d	cord printed 1/7/22, identified which included dementia.  S dated 10/8/21, indicated R9 itively impaired, required ependence with ADLs, and nent of bowel and bladder.  ed 7/12/19, indicated R9 was el and bladder and required an ination needs every two hours are after incontinent episodes. The plan indicated R9 was to independently carry out irected to assist with oral hands and face with cueing					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	CON	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 725	and extensive assist R9's documentation for the past four we provide documentation cares).  R10's Admission Residential and the pression.  R10's quarterly MD R10 had adequate understand and be was cognitively intarejection of cares. Endependence for AD as always incontined assess for incontined with each incontined with each incontined R10's output record four weeks. The fact records of intake and change.  On 1/6/22, at 3:49 pto wait a long time to because there was stated she sometime because that's whe	of cares and was requested eks. The facility was unable to tion of cares (check and ng, morning and evening ecord printed on 1/7/22, gnoses included hemiplegia, Alzheimer's disease, and S dated 11/5/21, indicated hearing and was able to understood. In addition R10 ct, had no behaviors or R10 required extensive to total Ls. R10's MDS identified her ent of bladder.  The definition of the past company to t	F 72	5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 725	On 1/6/22, at 3:58 stated she was tw for R9 and R10, bhelp. NA-B stated with the help of a to provide medicaresidents.  On 1/5/22, at 3:52 stated she was ur and change, repowhen she was the time of the interesidents who need the time of the interesidents who need the changed and repostaffing for the paranty one NA on the On 1/6/22, at 10:2 (LPN)-A stated the three NAs but it was one times it wou baths or showers typical day with twand repositioning gotten up and the who are not able to the last to be gotted to 1/6/22, at 11:3 shift to shift NA rewhen the resident stated when the resident stated stated stated when the resident stated when the resident stated when the resident stated	B p.m. nursing assistant (NA)-B to hours late with bedtime cares because there was not enough she was caring for 23 residents nurse who had responsibilities ations and treatments for the 23 p.m. nursing assistant (NA)-B hable to complete cares (check sitioning timely) for residents e only NA working for a shift. At erview she was the only staff on were three call lights ringing. B stated she had only been able and reposition four of the 15 eded to be checked and ositioned. NA-B stated the st two to three months has been e unit.  29 a.m. licensed practical nurse e staffing on days should be as typically only two. She stated ld only be one NA and then no are done. LPN-A stated on a to NAs the check and changes is not done timely, residents are in stay in their chairs, residents to communicate their needs are een up and ready for the day	F 7	725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	CON	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP OF 1201 8TH STREET SOUTH VIRGINIA, MN 55792		70172022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 725	addition, NA-C state went better but they change residents on 1/7/22, at 9:50 at (DON) verified residents and their between their call ligactivities staff are not residents and that the of practice. The DO system does not carepositioning so showere occurring as overified one NA workinge and repositioning so showere occurring as overified one NA workinge and repositioning treatments.  On 1/6/22, at 11:06 could be better and to COVID-19. RN-A assistants would not colleting and changemanner.  R1's documentation sheets for the last of Facility was unable.	ed when there are two NAs it were not able to check and reposition residents timely.  a.m. the director of nursing dents who are continent of have bladder accidents or orief because staff can't ht. The DON also verified ot trained to toilet or transfer his was not within their scope on verified the documentation apture check and changes or e could not be certain these care planned. The DON ald not be able to check and ion 15 residents timely and mely even with help from the e passing medications and  a.m., RN-A stated staffing that alot of staff are out due a confirmed that two nurse of be able to get turning, and completed in a timely our weeks was requested. To provide them.  ule for 1/6/22, indicated two sitions were covered for day positions that were not	F 72	5			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 18, 2022

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

Re: State Nursing Home Licensing Orders

Event ID: Q1DP11

#### Dear Administrator:

The above facility was surveyed on January 5, 2022 through January 7, 2022 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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 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:

Susan Frericks, Unit Supervisor Metro D District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health PO Box 64990 St. Paul MN 55164-0900

Email: susan.frericks@state.mn.us

Mobile: (218) 368-4467

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

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: 01/28/2022 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			,
		00582	B. WING			, 7/2022
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	nether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	conducted at your f Minnesota Departm facility was found N State Licensure. Plan of correction y	rS: a complaint survey was acility by surveyors from the nent of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou 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** 01/26/22

TITLE

STATE FORM 6899 If continuation sheet 1 of 24 Q1DP11

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMI	PLETED
						С
		00582	B. WING		01/	07/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
		1201 8TH	STREET SO	OUTH		
THE WA	TERVIEW PINES LLC		, MN 55792			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLETE DATE
					- /	
2 000	Continued From pa	age 1	2 000			
	The following comp	plaints were found to be				
	SUBSTANTIATED:					
	H5283039C (MN79	9525) with a licensing order				
	issued at S1805, S	0920, S0800.				
	H5283040C (MN79	9942) with no deficiencies.				
		nent of Health is documenting				
		Correction Orders using				
		Tag numbers have been				
	assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number					
		eft column entitled "ID Prefix				
		atute/rule out of compliance is				
		nary Statement of Deficiencies"				
	column and replace	es the "To Comply" portion of				
	the correction orde	r. This column also includes				
		are in violation of the state				
		atement, "This Rule is not met				
		ollowing the surveyor's findings				
	Time Period for Co	Method of Correction and				
		participate in the electronic				
		ensure orders consistent with				
	the Minnesota Dep					
		tin 14-01, available at				
		state.mn.us/facilities/regulatio				
	n/infobulletins/ib14	_1.html The State licensing				
		ed on the attached Minnesota				
	•	alth orders being submitted to				
		Although no plan of correction				
	_	ate Statutes/Rules, please				
		RRECTED" in the box our on the in the				
		ensure process, under the				
		n date, the date your orders will				
		o electronically submitting to				
		artment of Health. The facility				
		and therefore a signature is				

Minnesota Department of Health

STATE FORM Q1DP11 If continuation sheet 2 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		00582	B. WING		01/0	7/2022
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
THE WATERVIEW PINES LLC			STREET SO , MN 55792	DUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	not required at the l state form.	bottom of the first page of				
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements		2 800			2/2/22
	home must have or number of qualified registered nurses, I nursing assistants t residents at all nurs in all buildings if mo	requirements. A nursing of duty at all times a sufficient nursing personnel, including icensed practical nurses, and to meet the needs of the ses' stations, on all floors, and the pre than one building is under relief duty, weekends, tements.				
	by: Based on observati review, the facility for staffing was available for 4 of 7 residents repositioning for 1 or resident preferred was preference for 3 of This practice had the	on, interview, and document ailed to ensure sufficient ole to provide timely toileting (R1, R8, R9 and R10); timely of 1 residents (R2), and vake or bedtimes per 7 residents (R7, R9, R10). The potential to affect all e in the facility and require es.		Corrected		
	Findings include:					
	TOILETING					
		ated 1/7/22, indicated R1 had ease and rheumatoid arthritis.				
		num Data Set (MDS) dated R1 was cognitively intact and				

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Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
						;	
		00582	B. WING			7/2022	
NAME OF I	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  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 800	with toileting with or indicated typically or Incontinence has the On 1/6/22, at 9:10 a sitting in a soiled browhich was a hospital staff at 7:30 a.m. a hospital gown where R1 stated she then aide (AA)-A at 8:50 was delivered. R1 in she did not want to indicated she liked cleaned up, dressed breakfast was served when she had to us wait. R1 stated she to come when she like going in her bried on R1 stated she helft on commode for staffing.  On 1/6/22, at 11:00 knew R1 was soiled reported by AA-A. Now was reported to her many of the resider because of staffing several times when quickly enough to go NA-A stated they we aides on this hallward.	n. R1's MDS indicated assist coasional incontinence. MDS ontinent of bowel and bladder. The potential to impact dignity.  a.m., R1 indicated she was ief. R1 pointed to her clothing, all gown. R1 reported she told bout her soiled brief and in they made morning rounds. The reported it again to activity a.m. when her breakfast tray indicated she told AA-A that the eat in bed in a wet brief. R1 to get up in the morning, get do and in her chair before ed. R1 reported she could tell see the bathroom and tried to had urgency so staff needed called. She stated she did not ef but didn't know what else to had frequent soiled briefs, or in over an hour because of the a.m., NA-A reported she did at 8:30 a.m., when it was NA-A could not remember if it is earlier. NA-A reported that ints' cares are "way behind". She stated there were they could not get to them the residents on the commode. The residents on the commode and there were only two.	2 800				
	indicated R8's diag	cord printed on 1/7/22, noses included morbid ain, anxiety disorder, and					

Minnesota Department of Health

STATE FORM Q1DP11 If continuation sheet 4 of 24

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED
			71. 501251110.			c
		00582	B. WING		01/0	7/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE WATERVIEW PINES LLC 1201 8TH VIRGINIA,			STREET SC , MN 55792	DUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 4	2 800			
	depression.					
	11/24/21, indicated no rejections of car required extensive R8's MDS indicated	um Data Set (MDS) dated R8 was cognitively intact, had e or behaviors. In addition R8 assistance of one for ADLs. It she had seven or more r incontinence, but had at least tinence.				
	an alteration in mol	ed 11/24/20, indicated R8 had bility related to weakness and ance of one for toileting.				
		was requested for the past cility was unable to provide and output.				
	herself daily because to answer her call list already had three as on 1/6/22. R8 states her weekly shower enough staff. In adto wait longer than	o.m. R8 stated she "wets" se there were not enough staff ight. R8 stated she had accidents (bladder accidents) ed some days she did not get because there was not idition R8 stated she often had she would like to go to bed is too busy to help her.				
	PREFERENCES					
	R2 had diagnoses induced deep tissue chronic peripheral v	cord printed 1/7/22, indicated which included pressure e damage of left heel, and renous insufficiency (improper ein valves in the legs causing hanges).				
		um Data Set (MDS) dated R2 was cognitively intact,				

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STATE FORM Q1DP11 If continuation sheet 5 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
		00500	B WING		04/0		
		00582	D. WINO		01/0	7/2022	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THE WAT	TERVIEW PINES LLC		STREET SO MN 55792	DUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 800	Continued From pa	ge 5	2 800				
	daily living (ADLs), incontinent of bladd incontinence episod continence. In addit breakdown.	assistance with activities of and was occasionally ler with seven or more des but at least one episode of tion R2 was at risk for skin					
	required the assista	d 12/24/20, indicated R2 ince of one for all transfers. In d the assistance of one from					
		resident list printed 1/6/22, ed repositioning every two					
	takes awhile to be a are so busy. R2 sta accidents in her brid	o.m. R2 stated her call light answered because the staff ted sometimes she has ef because the staff don't t fast enough. R2 stated the mough staff.					
		a.m. during an observation of , R2 stated she slept through					
	R2's morning cares	a.m. during an observation of , nursing assistant (NA)-C as wet but not saturated.					
		ximately 11:30 a.m. activities I bringing R2 out of the bom.					
	able to reposition R	a.m. NA-C stated he was not 2 timely because he was ed there were only 2\two NAs should be three.					

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Minnesota Department of Health STATE FORM

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	L COMPL		
		7 t. BOILBING.			
	00582	B. WING		01/0	7/2022
PROVIDER OR SUPPLIER					
TERVIEW PINES LLC			DUTH		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETE DATE
On 1/6/22, at 2:12 p R2 to the bathroom wheelchair to the to wheelchair because there wasn't any sta  TOILEING AND PR R7's Admission Red diagnoses which ind (paralysis of one sid non-dominant side, wasting and atrophy R7's quarterly Minim 11/4/21, indicated R impaired and demo symptoms one to the extensive assistance activities of daily livi occasionally inconti R7's care plan date self-care deficit rela cognitive impairmen required assistance	o.m. A-B stated she brought, transferred from her bilet and back again to here are R2 "had to go so bad" and aff to take her to the bathroom.  EFERENCES  Cord printed 1/7/22, identified cluded dementia, hemiplegiate of the body) affecting left legal blindness, and muscle by.  The many common part of the best of the body of the b	2 800			
two hours and as no incontinence care w R7's care plan indicassistance of one for grooming.  R7's documentation requested for the pay was unable to provi	eeded and to provide with each incontinent episode. eated R7 required the or bathing, dressing, and of cares and output were ast four weeks. The facility de documentation of intake				
	PROVIDER OR SUPPLIER  FERVIEW PINES LLC  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETT)  Continued From pa  On 1/6/22, at 2:12 p R2 to the bathroom wheelchair to the to wheelchair because there wasn't any sta  TOILEING AND PR  R7's Admission Red diagnoses which ind (paralysis of one sid non-dominant side, wasting and atrophy  R7's quarterly Minimal 11/4/21, indicated Fimpaired and demosymptoms one to the extensive assistance activities of daily living occasionally incontinuated assistance of diagnoses two hours and as not incontinence care with the company of the province of the parameter of	OF CORRECTION  O0582  PROVIDER OR SUPPLIER  STREET ADD  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6  On 1/6/22, at 2:12 p.m. A-B stated she brought R2 to the bathroom, transferred from her wheelchair to the toilet and back again to her wheelchair because R2 "had to go so bad" and there wasn't any staff to take her to the bathroom.  TOILEING AND PREFERENCES  R7's Admission Record printed 1/7/22, identified diagnoses which included dementia, hemiplegia (paralysis of one side of the body) affecting left non-dominant side, legal blindness, and muscle wasting and atrophy.  R7's quarterly Minimum Data Set (MDS) dated 11/4/21, indicated R7 was severely cognitively impaired and demonstrated physical behavioral symptoms one to three days. R7 required extensive assistance to total dependence for activities of daily living. In addition R7 was occasionally incontinent of bladder.  R7's care plan dated 8/8/19 indicated R7 and a self-care deficit related to hemiplegia and cognitive impairment. R7's care plan indicated R7 required assistance of one for upper and lower body dressing. In addition, R7's care plan directed staff to assess R7 for incontinence every two hours and as needed and to provide incontinence care with each incontinent episode. R7's care plan indicated R7 required the assistance of one for bathing, dressing, and	OF CORRECTION  O0582  STREET ADDRESS, CITY, STREYIEW PINES LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6  On 1/6/22, at 2:12 p.m. A-B stated she brought R2 to the bathroom, transferred from her wheelchair to the toilet and back again to her wheelchair because R2 "had to go so bad" and there wasn't any staff to take her to the bathroom.  TOILEING AND PREFERENCES  R7's Admission Record printed 1/7/22, identified diagnoses which included dementia, hemiplegia (paralysis of one side of the body) affecting left non-dominant side, legal blindness, and muscle wasting and atrophy.  R7's quarterly Minimum Data Set (MDS) dated 11/4/21, indicated R7 was severely cognitively impaired and demonstrated physical behavioral symptoms one to three days. R7 required extensive assistance to total dependence for activities of daily living. In addition R7 was occasionally incontinent of bladder.  R7's care plan dated 8/8/19 indicated R7 and a self-care deficit related to hemiplegia and cognitive impairment. R7's care plan indicated R7 required assistance of one for upper and lower body dressing. In addition, R7's care plan indicated R7 required assistance of one for upper and lower body dressing. In addition, R7's care plan indicated R7 required the assistance of one for bathing, dressing, and grooming.  R7's documentation of cares and output were requested for the past four weeks. The facility was unable to provide documentation of intake	OF CORRECTION    DENTIFICATION NUMBER:   B. WING	OF CORRECTION OBS82  B. WING O1/10  ORONIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1201 8TH STREET SOUTH  VIRGINIA, MN 55792  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  On 1/6/22, at 2:12 p.m. A-B stated she brought R2 to the bathroom, transferred from her  wheelchair to the toilet and back again to her  wheelchair to the toilet and back again to her  wheelchair to the toilet and back again to her  wheelchair to the toilet and back again to her  wheelchair because R2 "had to go so bad" and there wasn't any staff to take her to the bathroom.  TOILEING AND PREFERENCES  R7's Admission Record printed 1/7/22, identified diagnoses which included dementia, hemiplegia (paralysis of one side of the body) affecting left non-dominant side, legal blindness, and muscle  wasting and atrophy.  R7's quarterly Minimum Data Set (MDS) dated 11/4/21, indicated R7 was severely cognitively impaired and demonstrated physical behavioral symptoms one to three days. R7 required extensive assistance to total dependence for activities of daily living. In addition R7 was occasionally incontinent of bladder.  R7's care plan dated 8/8/19 indicated R7 and a self-care deficit related to hemiplegia and cognitive impairment. R7's care plan indicated R7 required assistance of one for upper and lower body dressing. In addition, R7's care plan indicated R7 required assistance or one for upper and lower body dressing. In addition, R7's care plan indicated R7 required assistance care with each incontinence every two hours and as needed and to provide incontinence care with each incontinence every two hours and as needed and to provide incontinence care with each incontinence for incontinen

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Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
						С
		00582	B. WING		01/0	07/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO A, MN 55792	UTH		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 7	2 800			
		wable, using the reasonable people would not want to lie				
	On 1/6/22, at 10:29 a.m. licensed practical nurse (LPN)-A stated staff were not able to do morning cares and get R7 up for the day until noon on 1/5/22.					
	T	a.m. NA-C stated he was not efore noon on 1/5/22, because gh staff.				
	R9's Admission Record printed 1/7/22, identified R9 had diagnoses which included dementia.					
	R9's quarterly MDS dated 10/8/21, indicated R9 was severely cognitively impaired, required extensive to total dependence with ADLs, and was always incontinent of bowel and bladder.					
	incontinent of bowe assessment of elim with incontinence of In addition R9's car limited in her ability ADLs. Staff were di cares, washing of	d 7/12/19, indicated R9 was I and bladder and required an ination needs every two hours are after incontinent episodes. e plan indicated R9 was to independently carry out rected to assist with oral nands and face with cueing at of one for all other ADLs.				
	for the past four we provide documenta	n of cares and was requested eks. The facility was unable to tion of cares (check and ng, morning and evening				
		ecord printed on 1/7/22, gnoses included hemiplegia,				

Minnesota Department of Health STATE FORM

STATE FORM Q1DP11 If continuation sheet 8 of 24

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		C	
		00582	B. WING	<del></del>	I	7/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO , MN 55792	UTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 8	2 800			
	dementia, anxiety, depression.	Alzheimer's disease, and				
	R10 had adequate understand and be was cognitively inta rejection of cares. I	S dated 11/5/21, indicated hearing and was able to understood. In addition R10 let, had no behaviors or R10 required extensive to total Ls. R10's MDS identified her ent of bladder.				
	R10's care plan dated 9/5/19, directed staff to assess for incontinence every two hours and as needed/requested and provide incontinent cares with each incontinence episode.					
	four weeks. The fac	d was requested for the past cility was unable to provide and output or check and				
	to wait a long time is because there was stated she sometim because that's whe	o.m. R10 stated she often had to get her brief changed not enough staff. R10 also nes had to go to bed at 7 p.m. on the staff time to do it. R10 she would be in bed for 10-12 aid was too long.				
	stated she was two for R9 and R10, be help. NA-B stated s with the help of a n	o.m. nursing assistant (NA)-B hours late with bedtime cares cause there was not enough the was caring for 23 residents urse who had responsibilities ons and treatments for the 23				
	stated she was una	o.m. nursing assistant (NA)-B able to complete cares (check tioning timely) for residents				

Minnesota Department of Health

STATE FORM Q1DP11 If continuation sheet 9 of 24

		(X3) DATI COM	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		
	С		7. Bollbino.				
00582 B. WING 01/07/2022	_			B. WING	00582		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			STATE, ZIP CODE	DRESS, CITY, S	STREET AD	PROVIDER OR SUPPLIER	NAME OF
THE WATERVIEW PINES LLC  1201 8TH STREET SOUTH  VIRGINIA, MN 55792			UTH			TERVIEW PINES LLC	THE WA
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	(X5) COMPLETE DATE	CTION SHOULD BE O THE APPROPRIATE	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	ID PREFIX	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	(EACH DEFICIENCY	PRÉFIX
when she was the only NA working for a shift. At the time of the interview she was the only staff on the unit and there were three call lights ringingat 4:11 p.m. NA-B stated she had only been able to check and change and reposition four of the 15 residents who needed to be checked and changed and repositioned. NA-B stated the staffing for the past two to three months has been only one NA on the unit.  On 1/6/22, at 10:29 a.m. licensed practical nurse (LPN)-A stated the staffing on days should be three NAs but it was typically only two. She stated sometimes it would only be one NA and then no baths or showers are done. LPN-A stated on a typical day with two NAs the check and changes and repositioning is not done timely, residents are gotten up and then stay in their chairs, residents who are not able to communicate their needs are the last to be gotten up and ready for the day sometimes not until noon.  On 1/6/22, at 11:38 a.m. NA-C stated during the shift to shift NA report they are not always told when the resident was last repositioned. NA-C stated when there was only one NA on the day shift residents would not get their bath/shower. In addition, NA-C stated when there are two NAs it went better but they were not able to check and change residents or reposition residents timely.  On 1/7/22, at 9:50 a.m. the director of nursing (DON) verified residents who are continent of bladder should not have bladder accidents or have to go in their brief because staff can't answer their call light. The DON also verified activities staff are not trained to tollet or transfer residents and that this was not within their scope of practice. The DON verified the documentation system does not capture check and changes or				2 800	only NA working for a shift. At view she was the only staff on vere three call lights ringing. stated she had only been able ge and reposition four of the 15 led to be checked and itioned. NA-B stated the two to three months has been unit.  a.m. licensed practical nurse staffing on days should be stypically only two. She stated only be one NA and then no re done. LPN-A stated on a NAs the check and changes and done timely, residents are stay in their chairs, residents communicate their needs are in up and ready for the day I noon.  a.m. NA-C stated during the ort they are not always told was last repositioned. NA-C was only one NA on the day d not get their bath/shower. In ed when there are two NAs it were not able to check and r reposition residents timely.  a.m. the director of nursing dents who are continent of have bladder accidents or orief because staff can't ht. The DON also verified ot trained to toilet or transfer his was not within their scope on verified the documentation	when she was the of the time of the intersthe unit and there was 4:11 p.m. NA-B to check and changeresidents who need changed and repossaffing for the past only one NA on the On 1/6/22, at 10:29 (LPN)-A stated the three NAs but it was sometimes it would baths or showers a typical day with two and repositioning is gotten up and then who are not able to the last to be gotter sometimes not untion on 1/6/22, at 11:38 shift to shift NA reposition, NA-C stated when there was shift residents would addition, NA-C state went better but they change residents on on 1/7/22, at 9:50 at (DON) verified residents and that the of practice. The DC and the state of practice.	2 800

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00582	B. WING			C <b>07/2022</b>
	PROVIDER OR SUPPLIER TERVIEW PINES LLC	1201 8TH	DRESS, CITY, S STREET SO , MN 55792	STATE, ZIP CODE 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 800	repositioning so she were occurring as overified one NA wou change and reposit answer call lights tin nurse who would be doing treatments  On 1/6/22, at 11:06 could be better and to COVID-19. RN-A assistants would not toileting and changing manner.  R1's documentation sheets for the last of Facility was unable.  The working scheden nurse assistant possifit and two open of covered for day shift shift and two open of covered for day shift.  SUGGESTED MET The Director of Nur develop, review, an procedures to ensure and the control of the contr	e could not be certain these care planned. The DON ald not be able to check and ion 15 residents timely and mely even with help from the e passing medications and a.m., RN-A stated staffing that alot of staff are out due a confirmed that two nurse of be able to get turning, and completed in a timely our weeks was requested. To provide them.  The could not be certain these care planned and staff are out due a confirmed that two nurse of the able to get turning, and completed in a timely and repositioning our weeks was requested. The provide them are covered for day positions that were not	2 800			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(3) DATE SURVEY COMPLETED	
			71. BOILDING.				
		00582	B. WING		1	7/2022	
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
THE WAT	TERVIEW PINES LLC		STREET SO MN 55792	DUTH			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE	
2 900	MN Rule 4658.0525 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			2/2/22	
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which					
	without pressure so pressure sores unle condition demonstra	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and					
	receives necessary	ho has pressure sores y treatment and services to event infection, and prevent yeloping.					
	by: Based on observati review the facility fa	ent is not met as evidenced on, interview, and record illed to ensure a resident was for 1 of 1 residents (R2) tioning.		Corrected			
	Findings include:						
	R2 had diagnoses vinduced deep tissue chronic peripheral v	cord printed 1/7/22, indicated which included pressure e damage of left heel, and renous insufficiency (improper ein valves in the legs causing nanges).					
	11/30/21, indicated	ım Data Set (MDS) dated R2 was cognitively intact, assistance with activities of					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOLDING.		С	
		00582	B. WING			7/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO MN 55792	UTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	daily living (ADLs), incontinent of bladd incontinence episod continence. In addit breakdown.  R2's care plan date required the assistate addition, R2 required wheelchair to toilet.  R2's neighborhood indicated R2 required hours.  On 1/6/22, at 8:20 a observation from 8: assisted with morni into her wheelchair at 10:51 a.m. R2 wheelchair with herat 11:10 a staff me bathroom per R2's chair.  On 1/6/22, at 11:38 verified he was not timely, stating "too NAs on the day shift with check and charesidents.  On 1/7/22, at 9:50 at (DON) verified she reposition residents are not able to do thask for help.	and was occasionally ler with seven or more des but at least one episode of tion, R2 was at risk for skin and 12/24/20, indicated R2 ance of one for all transfers. In ed the assistance of one from resident list printed 1/6/22, ed repositioning every two a.m. during a continuous 20 a.m. to 11:20 a.m. R2 was ng cares and then assisted	2 900			
		purpose of repositioning to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED	
		00582	B. WING		1	7/2022
	PROVIDER OR SUPPLIER	1201 8TH	ORESS, CITY, S STREET SC MN 55792	STATE, ZIP CODE		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	circulation and pro- residents. The polic a chair should be or repositioning sched	breakdown, promote vide pressure relief for by directed resident who are in an every one hour ule.	2 900			
	The Director of Nur develop, review, an procedures to ensu according to their carried to their carried to the Director of Nur educate all appropring procedures. The Director of Nur develop monitoring compliance.	sing or designee could iate staff on the policies and sing or designee could systems to ensure ongoing				
2 920	MN Rule 4658.0525 Subp. 6. Activities comprehensive reshome must ensure B. a resident who activities of daily livi	is unable to carry out ing receives the necessary in good nutrition, grooming,	2 920			2/2/22
	by: Based on interview facility failed to ensi	and document review the ure residents had their ing (ADLs) completed for 5 of		Corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00582	B. WING		l l	C <b>07/2022</b>
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		STREET SO , MN 55792	DUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 14	2 920			
	7 residents (R1, R7 for ADLs.	, R8, R9, and R10) reviewed				
	Findings include:					
	diagnoses of rheun chronic kidney dise	inted 1/7/22, indicated R1 had natoid arthritis, stage IV ase, morbid obesity, diabetes with diabetic				
	R1's quarterly Minimum Data Set (MDS) dated 12/21/21, indicated R1 was cognitively intact, did not reject cares and required extensive assist of one with bed mobility, and total assist with transfers and toileting.					
	transferred with a c	ed 12/21/21 indicated R1 was eiling lift, assist of one for bed oileting, setup for meals and				
	undated, indicated	t daily assignment sheet R1 was to be turned every two t of one for transfers and to mobility.				
		n of cares and outputsfor the re requested but not provided.				
	broke on evening s fixed this morning. be used due to a property was in a soiled brie of all the issues. Rocleaned up, dresse eating breakfast.	a.m., R1 stated the ceiling lift hift last night and maintenance R1 stated the Hoyer could not rior concern. R1 stated she f and hospital gown because I stated she liked to get d and up in her chair prior to				
	On 1/6/22 at 0:10	m R1 was observed in her				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00582	B. WING		01/0	07/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	THE WATERVIEW PINES LLC 1201 8TI VIRGINIA			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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 15	2 920			
	bed in a hospital go the room.	wn; there was urine odor in				
	confirmed R1's ceili shift and it was not	a.m., nurse assistant (NA)-Aing lift had broken on a prior fixed until this a.m., shift. yar lift cannot be used on R1.				
	(LPN)-A stated on 1	a.m. licensed practical nurse 1/5/22, R7 did receive morning otten out of bed until noon				
	diagnoses which ind (paralysis of one side	cord printed 1/7/22, identified cluded dementia, hemiplegia de of the body) affecting left legal blindness, and muscle y.				
	11/4/21, indicated R impaired and demo symptoms one to the extensive assistance	num Data Set (MDS) dated R7 was severely cognitively nstrated physical behavioral aree days. R7 required the to total dependence for ing. In addition, R7 was nent of bladder.				
	self-care deficit rela cognitive impairmer required assistance body dressing. In ad directed staff to ass two hours and as no incontinence care w R7's care plan indic	d 8/8/19, indicated R7 had a sted to hemiplegia and ht. R7's care plan indicated R7 of one for upper and lower ddition, R7's care plan hess R7 for incontinence every seeded and to provide with each incontinent episode. Heated R7 required the probathing, dressing, and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
00582		B. WING			C <b>07/2022</b>	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE WATERVIEW PINES LLC		STREET SO , MN 55792	UTH			
(X4) ID SUMMARY STATEMENT OF DEFICE PREFIX (EACH DEFICIENCY MUST BE PRECENTED FOR THE PROPERTY OF LSC IDENTIFYING III	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
2 920 Continued From page 16 R7's documentation of cares and past four weeks were requested to the R7 was not interviewable, however reasonable person model, most powent to lie in bed until noon.  R8's Admission Record printed or indicated R8's diagnoses included obesity, low back pain, anxiety dis depression.  R8's annual Minimum Data Set (National Sectional Section Sectional Section Sectional Section Sectional Sectional Sectional Sectional Section Sectional Section Sectional Section Section Sectional Section Se	out not provided.  er, using the people would not a 1/7/22, a morbid sorder, and a morbid sorder, and a morbid sorder, and a morbid sorder, and a morbid sorder or ADLs. In addition R8 one for ADLs. In addition R8 one fo	2 920				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
			D WING		I	С	
		00582	B. WING		01/0	07/2022	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THE WA	TERVIEW PINES LLC		STREET SO , MN 55792	DUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
2 920	Continued From pa	ge 17	2 920				
	•	use staff are too busy to help					
	R9's Admission Record printed 1/7/22, identified R9 had diagnoses which included dementia.						
	was severely cogni extensive to total de	dated 10/8/21, indicated R9 tively impaired, required ependence with ADLs, and nent of bowel and bladder.					
	incontinent of bowe assessment of elim with incontinence c In addition R9's car limited in her ability ADLs. Staff were di cares, washing of h	ed 7/12/19, indicated R9 was all and bladder and required an ination needs every two hours are after incontinent episodes. The plan indicated R9 was to independently carry out irected to assist with oral ands and face with cueing st of one for all other ADLs.					
		n of cares for the past four ed but not provided.					
	indicated R10's dia	ecord printed on 1/7/22, gnoses included hemiplegia, Alzheimer's disease, and					
	R10 had adequate understand and be was cognitively inta rejection of cares. I	S dated 11/5/21, indicated hearing and was able to understood. In addition, R10 act, had no behaviors or R10 required extensive to total Ls. R10's MDS identified her ant of bladder.					
		ted 9/5/19, directed staff to ence every two hours and as					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00582	B. WING			0 <b>7/2022</b>
	PROVIDER OR SUPPLIER TERVIEW PINES LLC	STATE, ZIP CODE PUTH				
INE WA	IERVIEW FINES 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 18	2 920			
	needed/requested a with each incontine	and provide incontinent cares nce episode.				
	R10's output record was requested for the past four weeks. The facility was unable to provide records of this.					
	to bed at 7 p.m. bed could help her. R10	o.m. R10 stated she had to go cause that was when staff of further stated she ended up 2 hours and stated "that's too				
	stated she was two for R9 and R10, be- help. NA-B stated s with the help of a nu	o.m. nursing assistant (NA)-B hours late with bedtime cares cause there was not enough he was caring for 23 residents urse who had responsibilities ons and treatments for the 23				
	(DON) verified one expected to comple two hour repositioni timely for 23 reside would expect staff t	a.m. the director of nursing NA would not reasonably be te check and changes, everying, and answering call lights ints. The DON also verified she o answer call light promptly so the bladder accidents.				
	(ADLs), Supporting residents who were of daily living independent of the services necessary personal and oral health staff would provide for residents unable independently, with	titled Activities of Daily Living dated March 2018, indicated unable to carry out activities endently would receive the to maintain grooming and ygiene. The policy directed appropriate care and services e to carry out ADLs the consent of the resident with the plan of care.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
					C		
		00582	B. WING		01/0	7/2022	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THE WATERVIEW PINES LLC  1201 8TH STREET SOUTH  VIRGINIA, MN 55792							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 920	Continued From pa	ge 19	2 920				
	The Director of Nurdevelop, review, an procedures to ensu according to their care.	·					
	educate all appropr procedures. The Director of Nur	sing or designee could iate staff on the policies and sing or designee could systems to ensure ongoing					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21805	MN St. Statute 144. Residents of HC Fa	651 Subd. 5 Patients & ac.Bill of Rights	21805			2/2/22	
	residents have the courtesy and respec	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a					
	by: Based on observation review the facility factorized were continent of bouneeds met to prever associated embarration (R1, R8), in addition	on, interview, and document illed to ensure residents who owel and bladder had their nt bladder accidents and assment for 2 of 7 residents in preferences for bedtime of 7 residents (R8), reviewed lent rights.		Corrected			
	Findings include:						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
						;
		00582	B. WING		01/0	7/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WATERVIEW PINES LLC:			STREET SO , MN 55792	UTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	Continued From page 20		21805			
	R1's quarterly Minir 12/21/20, indicated had mild depressio with toileting with or R1 was typically co	ated 1/7/22, indicated R1 had ease and rheumatoid arthritis.  mum Data Set (MDS) dated R1 was cognitively intact and n. R1's MDS indicated assist ccasional incontinence, that ntinent of bowel and bladder ce had the potential to impact				
	sitting in a soiled br which was a hospit staff at 7:30 a.m., w rounds, that she wa then reported it aga 8:50 a.m. when her R1 indicated she to in bed in a wet brief up in the morning, of her chair before bre reported she could bathroom and tried urgency so staff ne	a.m., R1 indicated she was ief. R1 pointed to her clothing, al gown. R1 reported she told when they made morning as sitting in a soiled brief. She ain to activity aide (AA)-A at breakfast tray was delivered. Id AA A she did not want to eat f. R1 indicated she liked to get get cleaned up, dressed and in eakfast was served. R1 tell when she had to use the to wait. R1 stated she had eded to come when she she did not like going in her w what else to do.				
	and another staff m towels and a clean	a.m., nursing assistant (NA)-A nember entered R1's room with brief. On 1/6/22, at 9:38 a.m., itting in her chair, dressed and				
	resident reported the she would put call I she left the room, to	i.m., AA-A stated when a ney need to use the restroom ight on for resident and when ell staff. AA-A could not recall if I light on when she left the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00582	B. WING			C <b>07/2022</b>
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 COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 21	21805			
	room at 8:50 a.m. tl	hat morning.				
	On 1/6/22, from 8:1 light for R1 was not	5 a.m., to 9:30 a.m., the call activated.				
	knew R1 was soiled reported by AA-A. N was reported to her was aware that sitti extended time could On 1/6/22, at 2:00 p	a.m., NA-A reported she d at 8:30 a.m., when it was NA-A could not remember if it rearlier. NA-A reported she ng in a soiled brief for d affect dignity.  D.m., registered nurse (RN)-A and getting cleaned when				
		s a dignity concern.				
	indicated R8's diag	cord printed on 1/7/22, noses included morbid ain, anxiety disorder, and				
	11/24/21, indicated no rejections of car- required extensive a R8's MDS indicated	Im Data Set (MDS) dated R8 was cognitively intact, had e or behaviors. In addition, R8 assistance of one for ADLs. I she had seven or more incontinence, but had at least tinence.				
	an alteration in mob	d 11/24/20, indicated R8 had bility related to weakness and ance of one for toileting.				
	R8's output record to requested but not p	for the past four weeks was rovided.				
	(LPN)-A stated staff	a.m. licensed practical nurse f were not able to meet the nts. LPN-A stated showers				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00582	B. WING		l l	C <b>07/2022</b>
	PROVIDER OR SUPPLIER TERVIEW PINES LLC	1201 8TH	ORESS, CITY, S STREET SO MN 55792	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21805	were not getting do repositioning every were up in chairs the Specifically, LPN-A and changes and retimely.  On 1/6/22, at 3:38 pstated she was late ready for bed becaustaff.  On 1/6/22, at 3:49 pherself daily becauslight. R8 stated this "today". R8 was teat embarrassed and swait longer than she ready for bed becaust longer than she ready for bed because on the concern for dignity. The facility policy titrevised August 200 residents in a mannenhances quality of individuality. The podignity as maintaining self-esteem and sed directed to respond toileting assistance.	ne, check and changes, two hours, and once residents ney would stay up. stated on 1/5/22, the check epositioning were not done on. nursing assistant (NA)-B two hours or more to get R8 use there was not enough on. R8 stated she "wets" se staff don't answer her call had occurred three times arful and said it makes her feel ad. R8 also stated she has to be would like for staff to get her use staff are too busy to help on the commodated or nence episode it was a In addition, the DON verified a por bed time should be ommodated.  Iteled Quality of Life - Dignity 9, directed staff to care for the commodated of life, dignity, respect and of life, dignity to requests for	21805			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
					I	С	
		00582	B. WING		01/0	07/2022	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THE WA	THE WATERVIEW PINES LLC  1201 8TH STREET SOUTH  VIRGINIA, MN 55792						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
21805	Continued From pa	ge 23	21805				
	include self-determi existence.	ination and a dignified					
	The Director of Nur develop, review, an procedures to ensu are protected.  The Director of Nur educate all appropr procedures. The Director of Nur develop monitoring compliance.	THOD OF CORRECTION: sing or designee could d/or revise policies and re resident's dignity and rights sing or designee could iate staff on the policies and sing or designee could systems to ensure ongoing R CORRECTION: Twenty-one					

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