



Protecting, Maintaining and Improving the Health of All Minnesota

Electronically delivered
July 21, 2022

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

RE: CCN: 245283
Cycle Start Date: July 6, 2022

Dear Administrator:

On July 6, 2022, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) as evidenced by the electronically delivered CMS-2567,

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On June 29, 2022, the situation of immediate jeopardy to potential health and safety cited at F 760 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated

under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 6, 2022. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Waterview Pines Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 6, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

Facility Name()]

July 21, 2022

Page 4

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/lrc_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, Compliance Analyst
Minnesota Department of Health
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
July 21, 2022

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

Re: Event ID: KH0Y11

Dear Administrator:

The above facility survey was completed on July 6, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/06/2022
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/5/22, to 7/6/22, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The following complaint was SUBSTANTIATED at F760 for PAST NON-COMPLIANCE: H52832968C (MN84677), with a deficiency cited at F760. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. NO plan of correction is required for a finding of past non-compliance. The facility is still required to acknowledge receipt of the electronic documents.	F 000			
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from significant medication errors for 1 of 3 residents (R1) who received incorrect warfarin (anticoagulant/blood thinner) dosing. This deficient practice resulted in an immediate jeopardy (IJ) situation for R1, who required hospitalization with a critical INR (internationalized normalized ratio - a laboratory measurement of how long it takes blood to form a	F 760	Past noncompliance: no plan of correction required.		

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

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/06/2022	
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page 1 clot), and treatment for a low hemoglobin and further testing to determine the origin of the bleeding. The immediate jeopardy began on 6/20/22, when the pharmacy delivered bubble pack medication cards for warfarin packaged for two milligram (mg) tablets that actually contained 5 mg tablets. The error was discovered on 6/27/22, when registered nurse (RN)-B noted the warfarin tablets in the bubble pack medication card did not match the description typed on the Warfarin card. The IJ that began on 6/20/22, was corrected on 6/29/22 when the facility implemented interventions to prevent reoccurrence. The administrator, director of nursing (DON) and corporate administrator were notified of the IJ past noncompliance on 7/6/22, at 3:41 p.m., as a result of the immediate corrective action taken by the facility. Findings include: R1's Admission Record printed on 7/7/22, indicated R1 had diagnoses which included surgical aftercare following a fasciotomy (surgery to relieve swelling and pressure in a compartment of the body), acute post hemorrhagic anemia (a condition that develops when a person loses a large amount of blood quickly). R1's Coumadin use was related to a diagnosis of history of transient ischemic attack (TIA), and cerebral infarction without residual deficient (stroke). R1's admission Minimum Data Set (MDS) dated 6/23/22, indicated R1 was cognitively intact, required supervision with activities of daily living, and had a recent surgery involving tendons/ligaments/or muscles. The MDS also			F 760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/06/2022
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page 2 indicated R1 received anticoagulant medication. Review of R1's care plan, initiated on 6/20/22, indicated R1 was on anticoagulant therapy (medications that help prevent existing blood clots from growing larger and prevent the formation of new blood clots by increasing the amount of time it takes a blood clot to form). One of R1's goals was to be free of adverse reactions related to anticoagulant use. Interventions included labs as ordered and to report abnormal labs to the physician, to monitor/document/report as needed signs and symptoms of anticoagulant therapy. Signs and symptoms included blood tinged or frank blood in the urine, black tarry stools, dark or bright red blood in stools, sudden changes in mental status, or sudden changes in vital signs. R1's Order Summary Report printed on 7/7/22, included orders for Coumadin (a trade name for warfarin; used to treat and prevent blood clots) 5 mg, give one tablet by mouth in the evening every Monday, Wednesday, Friday, and Sunday. Warfarin 6 mg, give one tablet by mouth at bedtime every Tuesday, Thursday, and Saturday. According to the facility's investigative report dated 7/1/22, R1 had received the following doses of warfarin: 6/20/22, 12.5 mg 6/21/22, 15 mg 6/22/22, 12.5 mg 6/23/22, 15 mg 6/24/22, 12.5 mg 6/25/22, 15 mg 6/26/22, 12.5 mg	F 760			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/06/2022
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page 3 According to R1's physician orders dated 6/17/22, R1's warfarin doses should have been: 6/20/22, 5 mg 6/21/22, 6 mg 6/22/22, 5 mg 6/23/22, 6 mg 6/24/22, 5 mg 6/25/22, 6 mg 6/26/22, 5 mg R1's laboratory test dated 6/28/22, for INR resulted in a critical lab value of 10.8. An INR range of 2.0 to 3.0 is an effective therapeutic range for people taking warfarin. Review of R1's progress notes revealed the following: -6/28/22, at 2:43 p.m. INR was greater than 10.8 today. Review of why it was so high showed last night a nurse discovered that them (sp) Coumadin tabs, from the pharmacy/bubble pack had 5 mg tabs (peach) and should have been 2 mg (violet) tabs. R1 received too much Coumadin. Essentia Coumadin clinic called and was updated. New orders were to give Vitamin K [medication used for Warfarin overdose] stat and check a HGB [hemoglobin]. HG was 8.3 [healthy range for women is 11.6 to 15 grams per deciliter]. Hold Coumadin 6/28/22 and 6/29/22 and recheck INR 6/30/22. Stop Aspirin. -6/28/22, at 2:51 p.m. Spoke to R1 this morning about the Coumadin dosing and that we are holding the Coumadin today and tomorrow and she did not receive any last night after the nurse updated this writer. R1 reported she felt weak and was having a harder time with transfers and just	F 760			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/06/2022
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page 4 different (weaker) today. No blood noted in nose, urination, bowel. Drew blood today x 2 and R1 stopped bleeding immediately from her antecubital areas. No therapy today. Will continue to monitor. -6/28/22, at 5:27 p.m. R1 was in her recliner and states she was feeling very faint like, lightheaded and there was something not right. Yesterday she was doing therapy and transferring and today totally weak especially when standing/transferring. BP sitting 120/60, BP standing 60/40. When she stood she became very lightheaded and stated: "I'm going to faint." She sat down and was extremely weak. Call made to physician assistant (PA) to update. Order received to send to the emergency room (ER). 911 was called and ambulance arrived for transport. -6/28/22, at 9:48 p.m. R 1 was admitted to the hospital and received a blood transfusion at the ER. R1's hospital discharge summary dated 6/30/22, indicated R1 was admitted from the facility with dizziness, weakness, and melena (dark sticky feces) related secondary to unintentional Warfarin overdose. R1's course in the emergency room indicated she had a computerized tomography scan (a diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce images of the inside of the body) of abdomen and pelvis without clear gastrointestinal (GI) bleed, she did receive two units of packed red blood cells (PRBC) for anemia. R1's facility discharge summary dated 6/30/22, indicated R1 had a referral placed to general	F 760			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/06/2022
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page 5 surgery for endoscopy (a procedure used to look inside the body. An endoscopy can be used to look for a bleeding source). R1 was discharged home on 6/30/22. On 7/5/22, at 3:42 p.m. nurse consultant (NC)-A stated the pharmacy put five mg warfarin tablets in the medication bubble packets that were labeled as two mg warfarin tablets. NC-A stated the error was not discovered until RN-B found the error on 6/27/22, after R1 had received the wrong dose seven times. On 7/5/22, at 3:51 p.m. the director of nursing (DON) stated R1 was symptomatic from the medication error and was transferred to the ER for blood transfusion. The DON stated they were unsure of the source of R1's bleeding and she would need follow up to determine the cause of her low HG. On 7/5/22, at 3:58 p.m. licensed practical nurse (LPN)-A stated her had been educated on dosing for warfarin by the facility and would be a lot more careful and would make sure the pill color matched the pill in the medication bubble pack. On 7/6/22, at 9:02 a.m. an attempt was made to communicate with R1 and family member (FM)-F, but there was no response. On 7/6/22, at 9:18 a.m. medical director (MD)-C stated he would expect the medication coming from the pharmacy to be correct in the package. MD-C stated a double dose of warfarin would case a higher INR and a high INR would make the resident at risk for spontaneous bleeding. MD-C further stated usually a GI bleed would not be fatal. MD-C stated he would have expected	F 760			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/06/2022
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page 6 the facility to have notified the residents provider as soon as the medication error was discovered on 6/27/22. On 7/6/22, at 9:35 a.m. pharmacy manager (PM)-E verified there was a break down in the pharmacy's filling process when the warfarin pills were filled and 5 mg tablets were placed in a medication bubble pack labeled as 2 mg tablets. On 7/6/22, at 9:54 a.m. RN-A stated she received a message from RN-B on 6/27/22, at 7:55 p.m. who stated the warfarin pill color did not match the description of the pill color did not match the pill in the medication bubble pack. RN-A told RN-B not to give the medication and to put the card on her desk. RN-A did not realized the medication had been given for the previous six days. RN-A stated had she known that she would have had RN-B call a provider when the error was discovered. RN-A knew R1 was due for an INR lab draw on 6/28/22. RN-A stated she arrived at work at 8:30 a.m. on 6/28/22, and started her investigation. However, RN-A did not notify the administrator until 9:40 a.m. for reporting purposes. On 7/6/22, at 10:31 a.m. RN-B stated she noticed the warfarin pill was peach and should have been purple. When she punched the pill out into a medication cup she also noted there was a five on the pill. RN-B stated she called her manager and talked to her about it. Her manager told her to not give the dose and to put the medication back in the bubble pack and put it on her desk. RN-B was told to watch R1 for signs of bleeding. She was not told to call a provider about the error. On 7/6/22, at 11:07 a.m. the DON verified R1's	F 760			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/06/2022
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page 7 provider should have been notified immediately upon discovering the medication error. The DON stated the education for nursing staff and the TMA was started on 6/29/22, in person with staff who were working and by phone for staff who were not working. The policy titled Administering Medications dated 4/2019, directed staff to contact the resident's provider if a dosage was believed to be inappropriate, excessive, or if suspected of adverse consequences. The staff were directed to check the medication label three times to verify the right resident, right medication, right dosage, right time, and right route of medication before giving the medication. The past noncompliance immediate jeopardy began on 6/20/22, when the first incorrect dose of warfarin was given. The immediate jeopardy was removed on 6/29/22, when the facility implemented the following corrective actions: -Re-education of nursing staff on 6/29/22, on the six rights of medication administration on 6/29/22. A 6/29/22, nurse education sheet listed each staff name with a signature behind. Interviews with nursing staff on 7/6/22, verified knowledge of the correct process of checking the Coumadin chart, how to check the descriptions of pills and checking the dosage. -All current resident's Warfarin bubble packs were reviewed to ensure they were correctly packaged by the pharmacy -Added descriptions/pictures of Warfarin (color, printed mg) to each medication cart and on the bulletin board in the nurse's station on 6/29/22, as observed on 7/5/22, and 7/6/22. -On 6/29/22, the facility contacted the pharmacy	F 760			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/06/2022
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 760	Continued From page 8 about the error and about their new process going forward of checking the pill description and dosage. -They discussed at QAPI and with the medical director who was present at the QAPI meeting	F 760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00582	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/06/2022
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/5/22, to 7/6/22,, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00582	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/06/2022
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H52832968C. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00582	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/06/2022
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW PINES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Continued From page 2 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.	2 000			