Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 24, 2023

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

RE: CCN: 245283
Cycle Start Date: January 11, 2023

Dear Administrator:

On February 16, 2023, we notified you a remedy was imposed. On February 17, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 9, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 11, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 31, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 11, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 9, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us
cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 24, 2023

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

Re: Reinspection Results
Event ID: JXCG12

Dear Administrator:

On February 17, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 11, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

This Letter replaces the letter that was posted on January 26, 2023 to reflect the correct cycle start date.

Electronically delivered
February 1, 2023

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

RE: CCN: 245283
Cycle Start Date: January 11, 2023

Dear Administrator:

On January 11, 2023, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 11, 2023 (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 11, 2023 (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, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW PINES LLC	1201 8TH STREET SOUTH VIRGINIA, MN 55792

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/10/23, and 1/11/23, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be NOT in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H52837185C (MN00089844, MN00089847) with deficiencies cited at F565, F585. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.	F 565		2/9/23

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

Electronically Signed | 02/09/2023

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.

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F 565	Continued From page 1 (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed act upon grievances regarding care light response times aired during 4 of 5 resident council meetings reviewed. Findings include: Review of the Resident Council Meeting Minutes from 9/26/22, through 12/27/22, indicated the following: On 9/26/22, resident concerns included residents had to wait for over an hour for their call lights to	F 565	F565 – Resident/Family Group Response Immediate Corrective Action: R3's immediate needs were met during the time of the survey. Corrective Action as it applies to others: The Resident Council Policy was reviewed and remains current. All Resident Council Response Forms from last resident council meeting have been reviewed to determine if they were	

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F 565	Continued From page 2 be answered. This would be forwarded to the director of nursing (DON). On 10/31/22, concerns from the last meeting included call lights were not answered in a timely manner. The administrator would look into it as the DON was out on leave. On 12/5/22, resident concerns included call lights were still taking a long time to be answered. Residents had to wait for over an hour to go to the bathroom. The social service director (SSD) let the resident council know call light audits were being done, and the administrator reinforced the importance of timely answering of call light at the staff meetings. The concern would be referred to the DON. On 12/27/22, resident concerns from the last meeting included call lights were not answered in a timely manner. The DON let the council know the audits were still being done on call light response times, and there was still an issue of which the residents confirmed. The DON would continue to address the issue with the staff. On 1/10/23, at 1:34 p.m. the administrator and DON were interviewed. The administrator stated the call light system did not have the capabilities to provide a call light log for review. The DON stated call light monitoring was done when a resident or family reported long call light times. The DON stated no call light time audits or monitoring audits were completed. During an interview with a resident council member (R3) on 1/11/23, at 12:15 p.m. R3 stated there were a lot of complaints during the resident council meetings regarding having to wait a long	F 565	resolved appropriately. Clinical leaders, Administrator and Social Services will be educated on timely follow-up of Resident Council Response Forms. Date of Compliance: 2/9/23 Recurrence will be prevented by: All Resident Council Response forms from last resident council meeting will be reviewed to ensure they were resolved appropriately. This will occur monthly x 3 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit.	

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F 565	Continued From page 3 time after putting the call light on, a half an hour or longer. 1/11/23, at 1:33 p.m. call light audits were requested as stated in the resident council minutes. The administrator stated it was on his list of things to do, but other things came up and they were not done. The administrator stated he had a plan to get them done, and would make it a priority. The facility's Resident Council policy dated 4/17, directed a Resident Council Response form would be utilized to track issues and their resolution. The Quality Assurance and Performance Improvement (QAPI) committee would review information and feedback from the resident council as part of their quality review.	F 565		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585		2/9/23

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F 585	Continued From page 4 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as	F 585		

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F 585	Continued From page 5 necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure voiced grievances concerning call lights were addressed and	F 585	F585 – Grievances Immediate Corrective Action:	

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F 585	Continued From page 6 resolved to satisfaction for 2 of 3 residents (R1, R2) who reported dissatisfaction with extended wait times for call lights to be answered. Findings include: R1's Admission Record printed 1/11/23, indicated R1's diagnoses included chronic kidney disease, chronic pain, urinary tract infection (UTI), anxiety and depression. R1's quarterly Minimum Data Set (MDS) dated 1/4/23, indicated R1 was cognitively intact and did not have behaviors. R1 needed the extensive assistance of one staff for activities of daily living (ADLs), was occasionally incontinent of urine and was always continent of bowel. R1's care plan dated 10/19/20, indicated R1 was incontinent of bladder, wore an incontinent brief, and was able to make her needs known. R2's Admission Record printed 1/11/23, indicated R2's diagnoses included depression, panic disorder, anxiety, post-traumatic stress disorder, neuropathy and left foot drop. R2's care plan dated 11/23/22, indicated R2 needed the extensive assistance of one staff to transfer to and from the toilet, wheelchair, or recliner. R2 will call for assistance as needed. Two Minnesota Adult Abuse Reporting Center (MAARC) reports filed with the State Agency (SA) on 1/1/23, indicated on 1/1/23, R1 had not been getting the assistance she needed and had been sitting in her own excrement for some time. R1 had turned on her call light at approximately 8:45 p.m. and staff did not respond until approximately 9:30 p.m. During this time R1 had wet herself. R1	F 585	R1's & R2's immediate needs were met during the time of the survey. Corrective Action as it applies to others: The Complaint and Grievance Policy was reviewed and remains current. All resident grievances that have occurred within 30 days have been reviewed to determine if they were resolved appropriately. Clinical leaders, Administrator and Social Services will be educated on timely follow-up of resident grievances per policy. Date of Compliance: 2/9/23 Recurrence will be prevented by: All resident grievances from last week will be reviewed to ensure the resolution of the grievance is appropriate per facility policy. This will occur weekly x 4 weeks, then monthly x 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit.	

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F 585	Continued From page 7 stated the entire situation was humiliating and caused her anxiety and discomfort. A progress note dated 1/2/23, indicated R1's family member (FM)-A called and was concerned R1 was not feeling well. FM-A was worried R1 had a UTI because R1 had urinated in her incontinent brief yesterday and was not changed immediately. FM-A was also concerned about R1's mental health and mood. The social services director (SSD) assured FM-A she would speak with R1 to see if she had any concerns. When SSD spoke with R1, R1 stated she was feeling well and that things were good. SSD visited with R1 for about 20 minutes. Review of the facility Grievance Summaries from 10/12/22, through 12/22/22, indicated the following: On 10/21/22, R1 reported long call light wait times on 10/21/22. A summary of the investigation and findings indicated the night nurse was in another resident room completing medication administration when R1 put the call light on. The nursing assistant (NA) was busy in another room and the other two NAs were busy in a room on the other unit. R1's call light was answered as soon as staff were available. The action taken was the administrator was to complete call light audits. The grievance was resolved on 10/24/22, by the SSD. On 12/2/22, R2 reported he waited one and a half hours for his call light to be answered to get onto the toilet, and one hour for his call light to get answered to get off the toilet. A summary of the investigation and findings indicated on 12/1/22, the SSD spoke with R2 regarding call light times.	F 585		

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F 585	Continued From page 8	F 585		

R2 reported the staff caring for him was not available, and after an hour a different staff helped him onto the toilet. That staff was going to let the assigned staff know R2 was on the toilet. The assigned staff did not come and help R1 off the toilet. R2 reported this happened between 6:30 p.m. and 8:30 p.m. The action taken was intermittent call light audits were being completed, staff was reminded to communicate with each other about breaks, extensive cares, and to answer unassigned resident call lights if assigned staff was not available. The grievance was resolved on 12/2/22, by the SSD.

On 1/10/23, at 1:34 p.m. the administrator and DON were interviewed. The administrator stated the call light system did not have the capabilities to provide a call light log for review. The DON stated call light monitoring was done when a resident or family reported long call light times. The DON stated no call light time audits or monitoring audits were completed.

During an interview on 1/10/23, at 2:35 p.m. R1 stated long call light times occurred on all shifts. R1 stated on the weekend of New Year's, she had to wait at least an hour to get changed. R1 stated she was worried about getting a UTI as she gets UTIs easily. R1 stated she tried "like heck" to stay dry, but when her call light was not answered timely, she was incontinent. R1 further stated she was more susceptible to UTIs if she was incontinent of stool, and she has had to sit in stool for one and a half hours.

During an interview on 1/10/23, at 3:15 p.m. FM-A stated R1 was upset because R1 suspected she had a UTI. FM-A stated long call light times were the worst on weekends and holidays. FM-A stated

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	245283	A. BUILDING _____ B. WING _____	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW PINES LLC	1201 8TH STREET SOUTH VIRGINIA, MN 55792

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 9 R1 would sit in her incontinent brief soiled with urine and bowel movement and get an infection. FM-A stated R1 and herself had complained in the past and nothing was done. FM-A further stated ethically, this was not a good way to treat a human being. FM-A stated concern about residents who don't have a voice or someone to speak for them During an interview on 1/11/23, at 1:00 p.m. SSD stated she talked with FM-A often. SSD stated when R1 was lonely, she would make complaints which were difficult to prove. The SSD stated the facility was in the process of doing call light audits. During an interview with registered nurse (RN)-A on 1/11/23, at 12:35 p.m. RN-A stated R1 was typically continent, but could be incontinent if the urge came on quick. RN-A stated R1 knew when she has to use the bathroom and would put on the call light. RN-A stated R1 was usually continent of bowel if her call light was answered timely. During an interview with R2 on 1/11/23, at 12:45 p.m. R2 stated since filing the grievance, the call light response has been a "little quicker" with response time now a half an hour. 1/11/23, at 1:33 p.m. call light audits were requested as stated in the resident grievances. The administrator stated it was on his list of things to do, but other things came up and they were not done. The administrator stated he had a plan to get them done, and would make it a priority. The facility's Complaint and Grievance Procedure	F 585		

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F 585	Continued From page 10 policy dated 12/22, directed the administrator or designee would conduct an investigation of the grievance to determine its validity. The administrator or designee will issue a verbal or written summary to the complainant of the proposed action. If the administrator or designee does not resolve the grievance, the administrator must send the grievance to the corporate grievance office.	F 585		

Protecting, Maintaining and Improving the Health of All Minnesotans

This letter replaces the letter posted on January 31, 2023

Electronically delivered
February 1, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: JXCG11

Dear Administrator:

The above facility was surveyed on January 10, 2023 through January 11, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00582	A. BUILDING: _____ B. WING _____	C 01/11/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/10/23, and 1/11/23, 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. The following complaints were found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H52837185C (MN00089844, MN00089847) with licensing orders issued at 144.651 Subd. 20. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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		

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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		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not	21880		2/9/23

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21880	Continued From page 3 otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure voiced grievances concerning call lights were addressed and resolved to satisfaction for 2 of 3 residents (R1, R2) who reported dissatisfaction with extended wait times for call lights to be answered. Findings include: R1's Admission Record printed 1/11/23, indicated R1's diagnoses included chronic kidney disease, chronic pain, urinary tract infection (UTI), anxiety and depression. R1's quarterly Minimum Data Set (MDS) dated 1/4/23, indicated R1 was cognitively intact and did not have behaviors. R1 needed the extensive assistance of one staff for activities of daily living (ADLs), was occasionally incontinent of urine and was always continent of bowel. R1's care plan dated 10/19/20, indicated R1 was incontinent of bladder, wore an incontinent brief, and was able to make her needs known. R2's Admission Record printed 1/11/23, indicated	21880	Corrected	

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21880	Continued From page 4 R2's diagnoses included depression, panic disorder, anxiety, post-traumatic stress disorder, neuropathy and left foot drop. R2's care plan dated 11/23/22, indicated R2 needed the extensive assistance of one staff to transfer to and from the toilet, wheelchair, or recliner. R2 will call for assistance as needed. Two Minnesota Adult Abuse Reporting Center (MAARC) reports filed with the State Agency (SA) on 1/1/23, indicated on 1/1/23, R1 had not been getting the assistance she needed and had been sitting in her own excrement for some time. R1 had turned on her call light at approximately 8:45 p.m. and staff did not respond until approximately 9:30 p.m. During this time R1 had wet herself. R1 stated the entire situation was humiliating and caused her anxiety and discomfort. A progress note dated 1/2/23, indicated R1's family member (FM)-A called and was concerned R1 was not feeling well. FM-A was worried R1 had a UTI because R1 had urinated in her incontinent brief yesterday and was not changed immediately. FM-A was also concerned about R1's mental health and mood. The social services director (SSD) assured FM-A she would speak with R1 to see if she had any concerns. When SSD spoke with R1, R1 stated she was feeling well and that things were good. SSD visited with R1 for about 20 minutes. Review of the facility Grievance Summaries from 10/12/22, through 12/22/22, indicated the following: On 10/21/22, R1 reported long call light wait times on 10/21/22. A summary of the investigation and findings indicated the night	21880		

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21880	Continued From page 5 nurse was in another resident room completing medication administration when R1 put the call light on. The nursing assistant (NA) was busy in another room and the other two NAs were busy in a room on the other unit. R1's call light was answered as soon as staff were available. The action taken was the administrator was to complete call light audits. The grievance was resolved on 10/24/22, by the SSD. On 12/2/22, R2 reported he waited one and a half hours for his call light to be answered to get onto the toilet, and one hour for his call light to get answered to get off the toilet. A summary of the investigation and findings indicated on 12/1/22, the SSD spoke with R2 regarding call light times. R2 reported the staff caring for him was not available, and after an hour a different staff helped him onto the toilet. That staff was going to let the assigned staff know R2 was on the toilet. The assigned staff did not come and help R1 off the toilet. R2 reported this happened between 6:30 p.m. and 8:30 p.m. The action taken was intermittent call light audits were being completed, staff was reminded to communicate with each other about breaks, extensive cares, and to answer unassigned resident call lights if assigned staff was not available. The grievance was resolved on 12/2/22, by the SSD. On 1/10/23, at 1:34 p.m. the administrator and DON were interviewed. The administrator stated the call light system did not have the capabilities to provide a call light log for review. The DON stated call light monitoring was done when a resident or family reported long call light times. The DON stated no call light time audits or monitoring audits were completed. During an interview on 1/10/23, at 2:35 p.m. R1	21880		

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21880	Continued From page 6 stated long call light times occurred on all shifts. R1 stated on the weekend of New Year's, she had to wait at least an hour to get changed. R1 stated she was worried about getting a UTI as she gets UTIs easily. R1 stated she tried "like heck" to stay dry, but when her call light was not answered timely, she was incontinent. R1 further stated she was more susceptible to UTIs if she was incontinent of stool, and she has had to sit in stool for one and a half hours. During an interview on 1/10/23, at 3:15 p.m. FM-A stated R1 was upset because R1 suspected she had a UTI. FM-A stated long call light times were the worst on weekends and holidays. FM-A stated R1 would sit in her incontinent brief soiled with urine and bowel movement and get an infection. FM-A stated R1 and herself had complained in the past and nothing was done. FM-A further stated ethically, this was not a good way to treat a human being. FM-A stated concern about residents who don't have a voice or someone to speak for them During an interview on 1/11/23, at 1:00 p.m. SSD stated she talked with FM-A often. SSD stated when R1 was lonely, she would make complaints which were difficult to prove. The SSD stated the facility was in the process of doing call light audits. During an interview with registered nurse (RN)-A on 1/11/23, at 12:35 p.m. RN-A stated R1 was typically continent, but could be incontinent if the urge came on quick. RN-A stated R1 knew when she has to use the bathroom and would put on the call light. RN-A stated R1 was usually continent of bowel if her call light was answered timely.	21880		

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21880	Continued From page 7 During an interview with R2 on 1/11/23, at 12:45 p.m. R2 stated since filing the grievance, the call light response has been a "little quicker" with response time now a half an hour. 1/11/23, at 1:33 p.m. call light audits were requested as stated in the resident grievances. The administrator stated it was on his list of things to do, but other things came up and they were not done. The administrator stated he had a plan to get them done, and would make it a priority. The facility's Complaint and Grievance Procedure policy dated 12/22, directed the administrator or designee would conduct an investigation of the grievance to determine its validity. The administrator or designee will issue a verbal or written summary to the complainant of the proposed action. If the administrator or designee does not resolve the grievance, the administrator must send the grievance to the corporate grievance office. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and develop a plan to ensure residents complaints and grievances are being addressed promptly. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure resident(s) complaints and grievances are addressed on a timely basis. The results of these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		