Electronically delivered August 14, 2019

Administrator
The Waterview Woods Llc
601 Grant Avenue
Eveleth, MN 55734

RE: Project Number H5277024C

Dear Administrator:

On August 1, 2019, an abbreviated standard 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 20, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 20, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 20, 2019.

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

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 $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 20, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Waterview Woods Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 20, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor

Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 1, 2020 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW WOODS LLC	601 GRANT AVENUE EVELETH, MN 55734

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F 000	INITIAL COMMENTS From 7/30/19, to 8/1/19, an abbreviated standard survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5277024C 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 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686		8/21/19

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

Electronically Signed | 08/15/2019

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F 686	Continued From page 1 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive skin assessment, provide ongoing monitoring and develop interventions to promote healing and prevent further worsening for 1 of 1 resident (R1) who developed multiple pressure ulcers in the facility. This deficient practice resulted in actual harm for R1 who acquired three pressure ulcers (coccyx, gluteal fold and heel) and developed sepsis after the coccyx pressure ulcer became infected, was subsequently hospitalized and died. Findings include: Unstageable pressure ulcer (observed full thickness skin and tissue loss in which the extent of the damage cannot be confirmed due to the wound bed obscured with slough or eschar) Stage 3 pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muschle not exposed. Slough may be presnet but doe not obscure the depth of tissue loss. May include undermining and tunneling) Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough, may also present as an intact or open/ruptured blister) R1's admission Minimum Data Set (MDS) dated 5/8/19, indicated R1 had diagnoses which included Diabetes Mellitus, dementia and cardiomegaly (an enlarged heart). The MDS identified R1 had severe cognitive impairment	F 686	F Tag: F686 Pressure Ulcers POC Immediate Corrective Action: Resident #1 was discharged to hospital on 7/18/19. Corrective Action as it applies to others: The Policy for Skin Assessment and Wound Management remains current. Training on the Policy and Procedure for Skin Assessment and Wound Management, the Wound Process Checklist and the Weekly Skin Inspection was provided to the Administrator, DON, Infection Control Nurse and the 3 Unit Managers on 8/2/2019 by the Corporate Nurse Consultant. All licensed nursing staff will be trained on the Policy and Procedure for Skin Assessment, the Wound Process Checklist and the entire nursing staff on the Weekly Skin Inspection process. All residents with pressure ulcers will be reassessed utilizing the Wound Process Checklist to assure treatments are current, support surfaces are in place, repositioning plans are identified, and Care Plans are current. All residents in facility were assessed on 8/5/19 to ensure that there were no	

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F 686	Continued From page 2 and required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, dressing, toileting, personal hygiene, bathing and set up assistance with eating. The MDS further identified R1 was at risk for developing pressure ulcers and had no current pressure ulcers identified. The MDS revealed the following interventions were in place; pressure reducing device for R1's chair and bed. The MDS identified R1 had no weight loss and received a therapeutic diet for meals. The MDS further identified R1 was frequently incontinent of bladder and bowel. R1's annual Care Area Assessment (CAA) dated 5/14/19, indicated R1 required extensive assistance with ADL's due to weakness, poor balance and severe cognitive impairment. The CAA identified R1 was at risk for developing pressure ulcers due to she required staff assistance with relieving pressure, was confined to a bed or chair most of the time, required a special mattress or seat cushion to reduce or relieve pressure and moisture associated skin damage. The CAA further indicated R1 was at nutritional risk due to dementia, arthritis, contractures, functional limitation with range of motion and inability to perform ADL's without significant physical assistance. The CAA identified R1 had frequent bladder and bowel incontinence due to limited mobility, pain and frequent urinary tract infections. R1's care plan, revised 7/3/19, indicated R1 was at risk for pressure ulcers and had an alteration in skin integrity. R1's care plan listed various interventions which included pressure relieving mattress in bed, pressure relief cushion in wheelchair, lift do not slide, assistance from staff	F 686	unidentified skin concerns. Visual Wound rounds will occur weekly with the clinical leadership team and assessments completed following the rounds on all resident with pressure ulcers. Weekly Skin Inspections will be completed by nursing staff and any identified issues will be addressed timely. This will be an ongoing, weekly process. Wounds have been added to the morning stand up meeting to discuss and review. Date of Compliance: 8/19/2019 Recurrence will be prevented by: Visual Audits on all residents with pressure ulcers will be conducted by Nurse Manger or designee weekly x 4 then monthly x 2 to assure all assessments are completed timely, all treatments are appropriate, documentation is present, MD notification if indicated, and Care Plan is current. Audits will also be completed on 5 residents weekly by Nurse Manger or designee x 4 then monthly x2 to assure the Weekly Skin Inspections have been completed and any identified issues have been addressed timely. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/Nurse Managers	

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F 686	Continued From page 3	F 686		

to transfer, toilet and bed mobility. Further R1's care plan directed to observe skin with cares and report any changes to the licensed nurse, and complete weekly skin audits/evaluations by nurse on bath days, turn and reposition or reminders to offload every 2 hours and as needed, weekly measurements and assessment of wound, report and monitor for skin breakdown for signs/symptoms of infection and report any changes to MD.

R1's Skin Assessment with Braden Scale forms from 5/1/19 to 7/18/19 revealed the following:

- Skin Risk Assessment with Braden Scale (tool used to determine risk for pressure ulcer development) dated 5/1/19, indicated R1 had no pressure ulcers, was at risk for developing pressure ulcers due to acute condition, cognitive impairment, diabetes and requiring extensive assistance with bed mobility and occasional bowel incontinence. The assessment identified R1 had redness to her buttocks which was blanchable (area returns to normal skin color when pressure was applied and removed).

- Skin Risk Assessment with Braden Scale form dated 5/8/19, indicated R1 continued to be at risk for developing pressure ulcers and no current pressure ulcers were identified. The assessment identified R1 had moisture associated skin damage due to incontinence and continued to have pitting edema to her lower extremities. The assessment indicated R1 continued to have redness to her buttocks that was blanchable.

-Skin Risk Assessment with Braden Scale form dated 5/18/19, indicated R1 continued to be at risk for developing pressure ulcers and no current

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pressure ulcers were identified. The assessment identified R1 had moisture associated skin damage due to incontinence and pitting edema to her lower extremities. The assessment indicated R1 continued to have redness to her buttocks that was blanchable. The assessment indicated staff were to apply barrier cream after incontinence episodes, use of mechanical left for transfers, lift do not slide with repositioning, assist with transfers, toileting and bed mobility as needed and elevate l/e (lower extremities) throughout the day.

The medical record lacked any further skin assessments completed after 5/18/19.

Review of R1's progress notes from 5/1/19 to 7/18/19 revealed the following:

-5/1/19, redness to buttocks which was blanchable.

-5/8/19, redness to buttocks which was blanchable.

-5/10/19, redness to buttocks and barrier cream was being applied.

-5/17/19, continued to have redness to buttocks that was blanchable and staff were applying barrier cream.

-5/24/19, skin was clear and intact and did not address R1's skin on the buttocks.

-5/31/19, skin was clear and intact.

-6/7/19, yellow bruising to R1's left upper arm and the note lacked any further assessment of the

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F 686	Continued From page 5 rest of R1's skin. -6/14/19, weekly skin inspection completed by licensed nurse however had no results of the inspection documented. -6/29/19, staff applied a dressing to R1's "bottom" and administered pain medicaiton to R1 due to complaints of pain to her bottom. A later note indicated again staff placed a patch on R1's buttocks wound. The progress note lacked any description, measurement or staging of the pressure ulcer. R1's record lacked evidence of a comprehensive skin assessment completed including identifying causitive factors, contributing factors, nutrition, resident clinical condition and risk factors to develop approprate interventions to promote healing and prevent further pressure ulcers. -7/4/19, changed dressing to coccyx pressure ulcer. The progress note lacked any description, measurement or staging of the pressure ulcer. -7/7/19, coccyx pressure ulcer measured 4 cm. by 2.7 cm. with a depth of 0.4 cm. and classified as unstageable. The note identified the dark spot present on R1's pressure ulcer extended from R1's coccyx to the right buttocks and measured 3 cm. by 3 cm. The note indicated R1's right buttocks had pink, macerated and fragile skin that measured 2 cm. by 2.6 cm. related to urinary incontinence. The note further indicated R1 had four small open areas present on the right buttock which measured 1.6 cm. by 0.4, 0.6 cm x 0.8 cm., 1 cm x 0.6 cm and 0.2 cm x 0.2 cm.	F 686		

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-7/9/19, late entry 7/8/19, unstageable pressure ulcer on coccyx with 30% slough and 70% eschar, periwound skin dark pink does blanch. Stage 2 pressure ulcer in right gluteal fold with epithelial tissue. Developed a skin tear when bandage covering pressure ulcer removed. Area cleansed with soap and water, periwound skin treated with "no sting" barrier and sacral dressing applied.

-7/9/19, wound on coccyx changed, area cleansed with normal saline, dried and no sting barrier spray applied, new dressing applied. Later, a note indicated the dressing was changed due to saturation.

-7/12/19, dressing changed on "bottom", area cleansed and no sting applied and new dressing placed. No indication if changing change was done to the coccyx or gluteal fold pressure ulcer.

-7/12/19, resident seen by MD for sacral wound, new order for Bactrim DS(antibiotic) BID x 12 days, foley catheter due to urinary retention and "grade 3" sacral wound infected, 1/2 strength Dakins(antiseptic solution) wet to dry twice a day (BID) and as needed(PRN) covered with ABD(thick absorbent gauze dressing) pad. The note did not address treatment for the right gluteal fold pressure ulcer.

-7/13/19, dressing change done, area cleanses, new Dakins wet to dry, covered with ABD pad. Yelling throughout "help me", pain medication given prior to dressing change

-7/15/19, coccyx wound changed this shift, cleansed, new Dakins wet to dry, no sting and ABD pad applied. Foul odor from wound, starting

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to tunnel to right side. The note did not address measurements of the new tunnelling, current size of the pressure ulcer and did not address the right gluteal fold pressure ulcer.

-7/17/19, while turning resident noted a deep tissue injury (blister) on heel of right foot, measures 3.5 cm x 3.5 cm. noted resident pushing on bed with her heels. Implemented foam heel dressing and blue boots on at all times. A note later that day indicated dressing changed on coccyx, area cleansed, new Dakins wet to dry, ABD applied. Later that day, shaking and screaming help during wound care and for 1.5 hours after. Nurse sat with her for 20 minutes to provide reassurance, no interventions effective. Given pain medication which was ineffective. Also has new skin breakdown on the left hip/buttocks area. The notes did not address dressing change for the rght gluteal fold pressuer ulcer and did not include measurements, characterics, any possible drainage and treatment for the new open area on left hip/buttock area.

-7/18/19, daughter here and very concerned. Was here til 11:00 pm last evening and R1 moaning, appeared in pain, moving around a lot. She also reported R1 had a new open area on buttocks, family wanted her sent to the emergency room. The notes indicated R1 had been transferred to the emergency room approximately one hour later

Review of facility form titled Weekly Pressure Wound Evaluation from 5/1/19 to 7/18/19 revealed the following:

- 7/2/19, new unstageable pressure ulcer identified that measured 4 centimeters (cm.) in

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length, 2.7 cm. in width and 0.4 cm. in depth. The evaluation further indicated R1 had a dark spot extending from the coccyx to the right buttock that measured 3 cm. by 3 cm. Additionally, the right buttocks had pink macerated fragile skin that measured 2 cm. by 2.6 cm. and had four small open areas that measured 1.6 cm. by 0.4 cm., 0.6 cm. by 0.8 cm., 1 cm. by 0.6 cm. and 0.2 cm. by 0.2 cm. The evaluation identified R1's skin as fragile and macerated due to incontinence. The area was cleansed with wound cleanser and patted dry with a gauze dressing. A Mepilex (an absorbent foam dressing) dressing was applied to R1's coccyx as well as barrier cream.

-7/8/19, unstagable pressure ulcer to coccyx measured 5 cm. by 3.2 cm. with no depth noted. The wound had 30% slough and 70% eschar. Additionally, a pressure ulcer was noted to R1's right gluteal fold that measured 1.5 cm. by 1 cm. with 0.1 cm. of depth and classified as a stage two pressure ulcer. A scant amount of serosanguinous drainage was noted and an odor was present. The wound evaluation identified R1 spent the majority of her day sitting in her wheelchair or recliner and refused to stand due to fear of falling. An order was obtained for a sacral dressing to be changed every three days and as needed and staff were instructed to reposition or off load every two hours.

The medical record lacked any further Weekly Pressure Wound Evaluation forms completed after 7/8/19.

R1' clinical record lacked documentation the facilty conducted weekly monitoring of R1's multiple pressure ulcers which included location,

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size, depth, color, drainage, odor and staging of the pressure ulcers.

On 7/30/19, at 3:30 p.m. family member (FM)-A stated R1 did not have a pressure ulcer present upon admission to the facility. She indicated she had never seen the facility use special mattresses or cushions to aid in pressure ulcer prevention. FM-A stated the first two weeks of R1's stay went well and things deteriorated once R1 transferred to the second floor of the facility. She indicated she had been present on 7/12/19, during the medical doctor (MD)-A visit, MD-A had indicated they would be starting a treatment which consisted of a wash and staff would reposition R1 every two hours. She indicated R1's room had a foul odor lingering in the room, which she felt was from the infected pressure ulcer. FM-A indicated the night before R1 was transferred to the hospital, she had been informed the facility would be placing R1 on an air mattress. FM-A stated she had been very upset to learn the facility had an air mattress and had not started using it prior to that time. FM-A stated on the morning of 7/18/19, she asked the staff to transfer R1 to the hospital to be evaluated. FM-A stated the surgeon on duty (MD-B) informed her the pressure ulcer had started from the inside out and R1 may have had the wound for a long time. MD-B informed her a debridement of the wound was to be done that day due to the fact the pressure ulcer was infected.

On 7/31/19, at 8:35 a.m. during a telephone interview, MD-B verified he had been called for a surgical consult for R1 due to an infected pressure ulcer. MD-B stated he evaluated R1 when she was in the intensive care unit (ICU) and R1 was quite sick with low blood pressure and

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septic shock (potentially fatal condition in which sepsis leads to dangerously low blood pressure and abnormalities in cellular metabolism). MD-B stated he had a discussion with R1's family members present and explained R1 was in critical condition and R1 had a severe large foul smelling wound which had rotting slough and debris present. MD-B confirmed this type of wound was most commonly related to pressure at the site of the wound. MD-B estimated the size of the pressure ulcer upon his first evaluation to measure 10 cm. by 10 cm. with the surrounding skin necrotic and the center of the pressure ulcer black and foul smelling. MD-B verified R1's pressure ulcer was the major contributor of the development of sepsis. MD-B stated a significant amount of foul-smelling dead tissue had been debrided, the pressure ulcer had progressed to the bone and involved the bone. MD-B indicated after a second debridement, R1 had been placed on palliative care and subsequently passed away.

On 7/31/19, at 9:59 a.m. RN-A indicated R1 had been at risk for developing pressure ulcers and verified R1 did not have a pressure ulcer upon admission. RN-A stated R1 had not developed a pressure ulcer to her coccyx until after R1 moved from the first floor to the second floor. RN-A was not able to recall when R1 developed the pressure ulcer to her coccyx nor what stage the pressure ulcer was at when identified. RN-A indicated skin inspections were to be completed weekly on bath days. RN-A stated the process for skin inspections was for (nursing assistant) NA's to complete the skin inspection, document it on the facility Body Observation Sheet, give the sheet to the licensed nurse and the licensed nurse would then document in the medical record the results under the progress notes which were

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titled weekly skin inspection. RN-A reviewed the medical record and verified weekly skin inspections had not been completed on R1 in the month of June. Further, RN-A stated the pressure ulcer had been identified on 7/2/19 and had been classified as an unstageable pressure ulcer. RN-A reviewed the weekly facility Body Observation Sheets and verified on 6/25/19, the sheet indicated R1 had a bleeding sore. Further, RN-A verified the medical record lacked documentation of the wound developing on 6/25/19.

Review of R1's Body Observation Sheets completed by nursing assistants (NA) on resident bath days from-5/10/19 to 7/18/19 revealed the following:

-5/10/19, redness to buttocks and coccyx.

-5/24/19, intact skin with no redness to buttocks or coccyx.

-6/7/19, intact skin with no redness to buttocks or coccyx.

-6/14/19, redness to coccyx.

-6/18/19, intact skin with no redness to buttocks or coccyx.

-6/25/19,bleeding sore to coccyx.

-7/2/19, pressure ulcer to coccyx.

-7/9/19, pressure ulcer to coccyx.

R1's Weekly Skin Inspection,completed on 7/9/19 by licensed nursing staff, indicated R1 had

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an open area on her coccyx and new treatment orders were in place. Additionally, R1 had received a new cushion for her wheelchair and recliner. The inspection form indicated R1 would be turned and repositioned every two hours and as needed as resident allowed.

R1's medical record lacked any further Weekly Skin Inspection forms completed by licensed nursing staff, even though R1 had a pressure ulcer on her coccyx and gluteal fold.

On 7/31/19, 10:22 a.m. NA-A stated the process for skin inspections consisted of the NA's completing the forms on bath days and the inspections were given to the licensed nurse to enter into the medical record. In addition, NA-A stated he would inform the licensed nurse if he had noted any abnormalities during the inspection. NA-A stated he was not certain of the timing of when R1's pressure ulcer developed and stated the wound was large and had an odor to it. NA-A stated R1 would at times call out and say her bottom hurt.

On 7/31/19, 10:32 a.m. NA-F stated nursing assistants completed the body observations on bath days weekly and provided the sheet to the licensed nurse to analyze it. NA-F stated if she had noticed anything abnormal she would have informed the licensed nurse. NA-F stated she was not sure when R1's pressure ulcer developed and indicated R1's pressure ulcer was pretty big and had an odor to it.

On 7/31/19, at 11:43 a.m. NA-C stated R1's skin concerns developed after her move to second floor. NA-C stated she noticed R1's pressure ulcer to her coccyx around three weeks prior to

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R1 being hospitalized and further stated she had reported it to a licensed nurse. NA-C stated around two weeks before R1 was transferred to the hospital, the pressure ulcer had deteriorated to a hole and the skin surrounding R1's pressure ulcer was starting to die. NA-C further stated R1's pressure ulcer had an odor to it.

On 7/31/19, at 11:51 a.m. licensed pratical nurse (LPN)-A stated on 7/2/19, she noted R1 had a dressing to her coccyx area. LPN-A stated she had completed the dressing change once and R1's pressure ulcer had black tissue present.

On 7/31/19, at 12:05 p.m. director of nursing (DON) indicated she expected staff to complete weekly skin inspections on every resident. DON reviewed R1's medical record and confirmed R1's pressure ulcer had been identified on 7/2/19. DON reviewed R1's Body Observation Sheets and confirmed the presence of a bleeding sore on 6/25/19. DON confirmed he was not aware of the presence of a bleeding sore on R1 identified 6/25/19, and was not sure why it had been missed. After review of R1's medical record, DON confirmed weekly skin inspections, wound evaluations had not been completed for R1. He confirmed the last skin assessment had been done in May. DON stated R1 had been admitted to the hospital on 7/18/19, due to symptoms of shaking, whimpering and very diaphoretic. Further, DON stated the hospital informed the facility R1 had sepsis, dehydration and shock and expired on 7/20/19.

On 7/31/19, at 2:19 p.m. NA-E indicated R1's pressure ulcer developed a couple of weeks before R1 was hospitalized. NA-E stated R1's pressure ulcer started out as a tiny spot and

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within a week R1's pressure ulcer grew larger and started to develop black tissue. NA-E further stated R1's pressure ulcer within the next week or so became larger and developed even more black tissue to it.

On 7/31/19, at 2:33 p.m. during a follow-up interview, DON indicated the facility conducted an ad-hoc meeting that was similar to a root cause analysis after he had been notified of R1's hospitalization and death. DON confirmed no training had been provided to the staff regarding pressure ulcer identification and care since this incident. DON confirmed improvement in processes needed to occur to ensure residents were properly assessed and treated for pressure ulcers in the facility. Additionally, DON confirmed no auditing of cares had been completed and confirmed no changes to the facilty's process for pressure ulcer care had been completed at that time.

Review of physician's progress notes from 5/11/19 to 7/18/19 revealed the following:

-5/11/19, admitted to the facility from home with worsening dementia and significant generalized weakness and had a reluctance to walk due to low back pain which was new. Orders for physical therapy, occupational therapy and to continue previous cares. The note had no indication of R1 having any skin concerns at that time.

-6/4/19, physician note indicated the plan was to continue current orders. R1 had no skin issues identified at this visit.

-7/12/19, multiple family members were present for physician visit and had questions about R1's

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sacral wound as well as her continued urinary issues and dementia. The note indicated the sacral pressure ulcer developed and had progressively worsened due R1 refused to stand or walk or be turned. The plan in the note identified primary physician advised against sending R1 to the hospital for debridement due to outpatient care should be attempted first and indicators of a more systemic issue were not present at the time. New orders were received for nursing staff to insert a urinary catheter due to urinary retention and a significant sacral pressure ulcer. Additionally, new orders were received for R1 to start on antibiotics. The note indicated R1's pressure ulcer was classified as a stage three (full thickness skin loss potentially extending into the subcutaneous tissue) pressure ulcer. Plan was to follow-up in four weeks or sooner if needed.

On 8/1/19, at 9:20 a.m. during a telephone interview, MD-A stated R1's initial discharge plan was to participate in therapy to improve strength and function with the goal of returning home. MD-A stated R1 had dementia and had a fear of standing and falling and as a result was not getting up. MD-A stated during his last visit, R1 was seated in her recliner and appeared very uncomfortable. MD-A stated R1's pressure ulcer was pretty big and had a large amount of eschar present. MD-A stated he advised the family they would treat R1's pressure ulcer conservatively. MD-A stated the conservative approach had been attempted for about three days and then the family made the decision to transfer R1 to the hospital.

Review of faciltiy policy titled Skin Assessment and Wound Management dated 7/1/18, indicated

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the staff would complete a Braden scale assessment upon admission, weekly times three and when a significant change occurs. The policy instructed staff to notify licensed staff when skin changes were identified. The policy further instructed licensed staff to complete weekly skin inspections. Additionally, the policy instructed staff to notify the physician, family representative when a pressure ulcer was identified. The policy indicated staff were to initiate the weekly pressure ulcer wound evaluation weekly until healed.

The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2018, identified Section M: Skin Conditions to be completed to identify the risk, presence, appearance and change of pressure ulcers/injures. The manual defines a pressure ulcer/injury as a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure in combination of shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful. The manual further identified it was imperative to determine the etiology of all wounds and lesions as that would determine and direct the proper treatment and management of the wound.

- The manual defines an unstageable pressure ulcer/injury as "Known but not stageable due to coverage of wound bed by slough or eschar."

Electronically Delivered

August 14, 2019

Administrator
The Waterview Woods LLC
601 Grant Avenue
Eveleth, MN 55734

Re: State Nursing Home Licensing Orders - Complaint Number H5277024C

Dear Administrator:

A complaint investigation was completed on August 1, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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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 7/30/19, to 8/1/19, an unannounced abbreviated survey was conducted to determine compliance of State licensure for H5277024C and the complaint was substantiated. The following orders were issued.	2 000		

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2 000	Continued From page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive skin assessment, provide ongoing monitoring and develop interventions to promote healing and prevent further worsening for 1 of 1 resident (R1) who developed multiple pressure ulcers in the facility. This deficient practice resulted in actual harm for R1 who acquired three pressure ulcers (coccyx, gluteal fold and heel) and developed sepsis after the coccyx pressure ulcer became	2 900	F Tag: F686 Pressure Ulcers POC Immediate Corrective Action: Resident #1 was discharged to hospital on 7/18/19. Corrective Action as it applies to others: The Policy for Skin Assessment and Wound Management remains current.	8/21/19

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2 900	Continued From page 2 infected, was subsequently hospitalized and died. Findings include: Unstageable pressure ulcer (observed full thickness skin and tissue loss in which the extent of the damage cannot be confirmed due to the wound bed obscured with slough or eschar) Stage 3 pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muschle not exposed. Slough may be presnet but doe not obscure the depth of tissue loss. May include undermining and tunneling) Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough, may also present as an intact or open/ruptured blister) R1's admission Minimum Data Set (MDS) dated 5/8/19, indicated R1 had diagnoses which included Diabetes Mellitus, dementia and cardiomegaly (an enlarged heart). The MDS identified R1 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, dressing, toileting, personal hygiene, bathing and set up assistance with eating. The MDS further identified R1 was at risk for developing pressure ulcers and had no current pressure ulcers identified. The MDS revealed the following interventions were in place; pressure reducing device for R1's chair and bed. The MDS identified R1 had no weight loss and received a therapeutic diet for meals. The MDS further identified R1 was frequently incontinent of bladder and bowel. R1's annual Care Area Assessment (CAA) dated	2 900	Training on the Policy and Procedure for Skin Assessment and Wound Management, the Wound Process Checklist and the Weekly Skin Inspection was provided to the Administrator, DON, Infection Control Nurse and the 3 Unit Managers on 8/2/2019 by the Corporate Nurse Consultant. All licensed nursing staff will be trained on the Policy and Procedure for Skin Assessment, the Wound Process Checklist and the entire nursing staff on the Weekly Skin Inspection process. All residents with pressure ulcers will be reassessed utilizing the Wound Process Checklist to assure treatments are current, support surfaces are in place, repositioning plans are identified, and Care Plans are current. All residents in facility were assessed on 8/5/19 to ensure that there were no unidentified skin concerns. Visual Wound rounds will occur weekly with the clinical leadership team and assessments completed following the rounds on all resident with pressure ulcers. Weekly Skin Inspections will be completed by nursing staff and any identified issues will be addressed timely. This will be an ongoing, weekly process. Wounds have been added to the morning stand up meeting to discuss and review. Date of Compliance: 8/19/2019 Recurrence will be prevented by:	

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2 900	Continued From page 3 5/14/19, indicated R1 required extensive assistance with ADL's due to weakness, poor balance and severe cognitive impairment. The CAA identified R1 was at risk for developing pressure ulcers due to she required staff assistance with relieving pressure, was confined to a bed or chair most of the time, required a special mattress or seat cushion to reduce or relieve pressure and moisture associated skin damage. The CAA further indicated R1 was at nutritional risk due to dementia, arthritis, contractures, functional limitation with range of motion and inability to perform ADL's without significant physical assistance. The CAA identified R1 had frequent bladder and bowel incontinence due to limited mobility, pain and frequent urinary tract infections. R1's care plan, revised 7/3/19, indicated R1 was at risk for pressure ulcers and had an alteration in skin integrity. R1's care plan listed various interventions which included pressure relieving mattress in bed, pressure relief cushion in wheelchair, lift do not slide, assistance from staff to transfer, toilet and bed mobility. Further R1's care plan directed to observe skin with cares and report any changes to the licensed nurse, and complete weekly skin audits/evaluations by nurse on bath days, turn and reposition or reminders to offload every 2 hours and as needed, weekly measurements and assessment of wound, report and monitor for skin breakdown for signs/symptoms of infection and report any changes to MD. R1's Skin Assessment with Braden Scale forms from 5/1/19 to 7/18/19 revealed the following: - Skin Risk Assessment with Braden Scale (tool used to determine risk for pressure ulcer	2 900	Visual Audits on all residents with pressure ulcers will be conducted by Nurse Manger or designee weekly x 4 then monthly x 2 to assure all assessments are completed timely, all treatments are appropriate, documentation is present, MD notification if indicated, and Care Plan is current. Audits will also be completed on 5 residents weekly by Nurse Manger or designee x 4 then monthly x2 to assure the Weekly Skin Inspections have been completed and any identified issues have been addressed timely. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/Nurse Managers	

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2 900	Continued From page 4 development) dated 5/1/19, indicated R1 had no pressure ulcers, was at risk for developing pressure ulcers due to acute condition, cognitive impairment, diabetes and requiring extensive assistance with bed mobility and occasional bowel incontinence. The assessment identified R1 had redness to her buttocks which was blanchable (area returns to normal skin color when pressure was applied and removed). - Skin Risk Assessment with Braden Scale form dated 5/8/19, indicated R1 continued to be at risk for developing pressure ulcers and no current pressure ulcers were identified. The assessment identified R1 had moisture associated skin damage due to incontinence and continued to have pitting edema to her lower extremities. The assessment indicated R1 continued to have redness to her buttocks that was blanchable. -Skin Risk Assessment with Braden Scale form dated 5/18/19, indicated R1 continued to be at risk for developing pressure ulcers and no current pressure ulcers were identified. The assessment identified R1 had moisture associated skin damage due to incontinence and pitting edema to her lower extremities. The assessment indicated R1 continued to have redness to her buttocks that was blanchable. The assessment indicated staff were to apply barrier cream after incontinence episodes, use of mechanical left for transfers, lift do not slide with repositioning, assist with transfers, toileting and bed mobility as needed and elevate l/e (lower extremities) throughout the day. The medical record lacked any further skin assessments completed after 5/18/19. Review of R1's progress notes from 5/1/19 to	2 900		

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2 900	Continued From page 5 7/18/19 revealed the following: -5/1/19, redness to buttocks which was blanchable. -5/8/19, redness to buttocks which was blanchable. -5/10/19, redness to buttocks and barrier cream was being applied. -5/17/19, continued to have redness to buttocks that was blanchable and staff were applying barrier cream. -5/24/19, skin was clear and intact and did not address R1's skin on the buttocks. -5/31/19, skin was clear and intact. -6/7/19, yellow bruising to R1's left upper arm and the note lacked any further assessment of the rest of R1's skin. -6/14/19, weekly skin inspection completed by licensed nurse however had no results of the inspection documented. -6/29/19, staff applied a dressing to R1's "bottom" and administered pain medicaiton to R1 due to complaints of pain to her bottom. A later note indicated again staff placed a patch on R1's buttocks wound. The progress note lacked any description, measurement or staging of the pressure ulcer. R1's record lacked evidence of a comprehensive skin assessment completed including identifying causitive factors, contributing factors, nutrition, resident clinical condition and	2 900		

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2 900	Continued From page 6 risk factors to develop approprate interventions to promote healing and prevent further pressure ulcers. -7/4/19, changed dressing to coccyx pressure ulcer. The progress note lacked any description, measurement or staging of the pressure ulcer. -7/7/19, coccyx pressure ulcer measured 4 cm. by 2.7 cm. with a depth of 0.4 cm. and classified as unstageable. The note identified the dark spot present on R1's pressure ulcer extended from R1's coccyx to the right buttocks and measured 3 cm. by 3 cm. The note indicated R1's right buttocks had pink, macerated and fragile skin that measured 2 cm. by 2.6 cm. related to urinary incontinence. The note further indicated R1 had four small open areas present on the right buttock which measured 1.6 cm. by 0.4, 0.6 cm x 0.8 cm., 1 cm x 0.6 cm and 0.2 cm x 0.2 cm. -7/9/19, late entry 7/8/19, unstageable pressure ulcer on coccyx with 30% slough and 70% eschar, periwound skin dark pink does blanch. Stage 2 pressure ulcer in right gluteal fold with epithelial tissue. Developed a skin tear when bandage covering pressure ulcer removed. Area cleansed with soap and water, periwound skin treated with "no sting" barrier and sacral dressing applied. -7/9/19, wound on coccyx changed, area cleansed with normal saline, dried and no sting barrier spray applied, new dressing applied. Later, a note indicated the dressing was changed due to saturation. -7/12/19, dressing changed on "bottom", area cleansed and no sting applied and new dressing placed. No indication if changing change was	2 900		

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2 900	Continued From page 7 done to the coccyx or gluteal fold pressure ulcer. -7/12/19, resident seen by MD for sacral wound, new order for Bactrim DS(antibiotic) BID x 12 days, foley catheter due to urinary retention and "grade 3" sacral wound infected, 1/2 strength Dakins(antiseptic solution) wet to dry twice a day (BID) and as needed(PRN) covered with ABD(thick absorbent gauze dressing) pad. The note did not address treatment for the right gluteal fold pressure ulcer. -7/13/19, dressing change done, area cleanses, new Dakins wet to dry, covered with ABD pad. Yelling throughout "help me", pain medication given prior to dressing change -7/15/19, coccyx wound changed this shift, cleansed, new Dakins wet to dry, no sting and ABD pad applied. Foul odor from wound, starting to tunnel to right side. The note did not address measurements of the new tunnelling, current size of the pressure ulcer and did not address the right gluteal fold pressure ulcer. -7/17/19, while turning resident noted a deep tissue injury (blister) on heel of right foot, measures 3.5 cm x 3.5 cm. noted resident pushing on bed with her heels. Implemented foam heel dressing and blue boots on at all times. A note later that day indicated dressing changed on coccyx, area cleansed, new Dakins wet to dry, ABD applied. Later that day, shaking and screaming help during wound care and for 1.5 hours after. Nurse sat with her for 20 minutes to provide reassurance, no interventions effective. Given pain medication which was ineffective. Also has new skin breakdown on the left hip/buttocks area. The notes did not address dressing change for the rght gluteal fold pressuer ulcer and did not	2 900		

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2 900	Continued From page 8 include measurements, characterics, any possible drainage and treatment for the new open area on left hip/buttock area. -7/18/19, daughter here and very concerned. Was here til 11:00 pm last evening and R1 moaning, appeared in pain, moving around a lot. She also reported R1 had a new open area on buttocks, family wanted her sent to the emergency room. The notes indicated R1 had been transferred to the emergency room approximately one hour later Review of facility form titled Weekly Pressure Wound Evaluation from 5/1/19 to 7/18/19 revealed the following: - 7/2/19, new unstageable pressure ulcer identified that measured 4 centimeters (cm.) in length, 2.7 cm. in width and 0.4 cm. in depth. The evaluation further indicated R1 had a dark spot extending from the coccyx to the right buttock that measured 3 cm. by 3 cm. Additionally, the right buttocks had pink macerated fragile skin that measured 2 cm. by 2.6 cm. and had four small open areas that measured 1.6 cm. by 0.4 cm., 0.6 cm. by 0.8 cm., 1 cm. by 0.6 cm. and 0.2 cm. by 0.2 cm. The evaluation identified R1's skin as fragile and macerated due to incontinence. The area was cleansed with wound cleanser and patted dry with a gauze dressing. A Mepilex (an absorbent foam dressing) dressing was applied to R1's coccyx as well as barrier cream. -7/8/19, unstagable pressure ulcer to coccyx measured 5 cm. by 3.2 cm. with no depth noted. The wound had 30% slough and 70% eschar. Additionally, a pressure ulcer was noted to R1's right gluteal fold that measured 1.5 cm. by 1 cm.	2 900		

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with 0.1 cm. of depth and classified as a stage two pressure ulcer. A scant amount of serosanguinous drainage was noted and an odor was present. The wound evaluation identified R1 spent the majority of her day sitting in her wheelchair or recliner and refused to stand due to fear of falling. An order was obtained for a sacral dressing to be changed every three days and as needed and staff were instructed to reposition or off load every two hours.

The medical record lacked any further Weekly Pressure Wound Evaluation forms completed after 7/8/19.

R1' clinical record lacked documentation the facilty conducted weekly monitoring of R1's multiple pressure ulcers which included location, size, depth, color, drainage, odor and staging of the pressure ulcers.

On 7/30/19, at 3:30 p.m. family member (FM)-A stated R1 did not have a pressure ulcer present upon admission to the facility. She indicated she had never seen the facility use special mattresses or cushions to aid in pressure ulcer prevention. FM-A stated the first two weeks of R1's stay went well and things deteriorated once R1 transferred to the second floor of the facility. She indicated she had been present on 7/12/19, during the medical doctor (MD)-A visit, MD-A had indicated they would be starting a treatment which consisted of a wash and staff would reposition R1 every two hours. She indicated R1's room had a foul odor lingering in the room, which she felt was from the infected pressure ulcer. FM-A indicated the night before R1 was transferred to the hospital, she had been informed the facility would be placing R1 on an air mattress. FM-A stated she had been very upset to learn the facility had

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an air mattress and had not started using it prior to that time. FM-A stated on the morning of 7/18/19, she asked the staff to transfer R1 to the hospital to be evaluated. FM-A stated the surgeon on duty (MD-B) informed her the pressure ulcer had started from the inside out and R1 may have had the wound for a long time. MD-B informed her a debridement of the wound was to be done that day due to the fact the pressure ulcer was infected.

On 7/31/19, at 8:35 a.m. during a telephone interview, MD-B verified he had been called for a surgical consult for R1 due to an infected pressure ulcer. MD-B stated he evaluated R1 when she was in the intensive care unit (ICU) and R1 was quite sick with low blood pressure and septic shock (potentially fatal condition in which sepsis leads to dangerously low blood pressure and abnormalities in cellular metabolism). MD-B stated he had a discussion with R1's family members present and explained R1 was in critical condition and R1 had a severe large foul smelling wound which had rotting slough and debris present. MD-B confirmed this type of wound was most commonly related to pressure at the site of the wound. MD-B estimated the size of the pressure ulcer upon his first evaluation to measure 10 cm. by 10 cm. with the surrounding skin necrotic and the center of the pressure ulcer black and foul smelling. MD-B verified R1's pressure ulcer was the major contributor of the development of sepsis. MD-B stated a significant amount of foul-smelling dead tissue had been debrided, the pressure ulcer had progressed to the bone and involved the bone. MD-B indicated after a second debridement, R1 had been placed on palliative care and subsequently passed away.

On 7/31/19, at 9:59 a.m. RN-A indicated R1 had

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been at risk for developing pressure ulcers and verified R1 did not have a pressure ulcer upon admission. RN-A stated R1 had not developed a pressure ulcer to her coccyx until after R1 moved from the first floor to the second floor. RN-A was not able to recall when R1 developed the pressure ulcer to her coccyx nor what stage the pressure ulcer was at when identified. RN-A indicated skin inspections were to be completed weekly on bath days. RN-A stated the process for skin inspections was for (nursing assistant) NA's to complete the skin inspection, document it on the facility Body Observation Sheet, give the sheet to the licensed nurse and the licensed nurse would then document in the medical record the results under the progress notes which were titled weekly skin inspection. RN-A reviewed the medical record and verified weekly skin inspections had not been completed on R1 in the month of June. Further, RN-A stated the pressure ulcer had been identified on 7/2/19 and had been classified as an unstageable pressure ulcer. RN-A reviewed the weekly facility Body Observation Sheets and verified on 6/25/19, the sheet indicated R1 had a bleeding sore. Further, RN-A verified the medical record lacked documentation of the wound developing on 6/25/19.

Review of R1's Body Observation Sheets completed by nursing assistants (NA) on resident bath days from-5/10/19 to 7/18/19 revealed the following:

-5/10/19, redness to buttocks and coccyx.

-5/24/19, intact skin with no redness to buttocks or coccyx.

-6/7/19, intact skin with no redness to buttocks or

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2 900	Continued From page 12 coccyx. -6/14/19, redness to coccyx. -6/18/19, intact skin with no redness to buttocks or coccyx. -6/25/19,bleeding sore to coccyx. -7/2/19, pressure ulcer to coccyx. -7/9/19, pressure ulcer to coccyx. R1's Weekly Skin Inspection,completed on 7/9/19 by licensed nursing staff, indicated R1 had an open area on her coccyx and new treatment orders were in place. Additionally, R1 had received a new cushion for her wheelchair and recliner. The inspection form indicated R1 would be turned and repositioned every two hours and as needed as resident allowed. R1's medical record lacked any further Weekly Skin Inspection forms completed by licensed nursing staff, even though R1 had a pressure ulcer on her coccyx and gluteal fold. On 7/31/19, 10:22 a.m. NA-A stated the process for skin inspections consisted of the NA's completing the forms on bath days and the inspections were given to the licensed nurse to enter into the medical record. In addition, NA-A stated he would inform the licensed nurse if he had noted any abnormalities during the inspection. NA-A stated he was not certain of the timing of when R1's pressure ulcer developed and stated the wound was large and had an odor to it. NA-A stated R1 would at times call out and say her bottom hurt.	2 900		

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2 900	Continued From page 13 On 7/31/19, 10:32 a.m. NA-F stated nursing assistants completed the body observations on bath days weekly and provided the sheet to the licensed nurse to analyze it. NA-F stated if she had noticed anything abnormal she would have informed the licensed nurse. NA-F stated she was not sure when R1's pressure ulcer developed and indicated R1's pressure ulcer was pretty big and had an odor to it. On 7/31/19, at 11:43 a.m. NA-C stated R1's skin concerns developed after her move to second floor. NA-C stated she noticed R1's pressure ulcer to her coccyx around three weeks prior to R1 being hospitalized and further stated she had reported it to a licensed nurse. NA-C stated around two weeks before R1 was transferred to the hospital, the pressure ulcer had deteriorated to a hole and the skin surrounding R1's pressure ulcer was starting to die. NA-C further stated R1's pressure ulcer had an odor to it. On 7/31/19, at 11:51 a.m. licensed pratical nurse (LPN)-A stated on 7/2/19, she noted R1 had a dressing to her coccyx area. LPN-A stated she had completed the dressing change once and R1's pressure ulcer had black tissue present. On 7/31/19, at 12:05 p.m. director of nursing (DON) indicated she expected staff to complete weekly skin inspections on every resident. DON reviewed R1's medical record and confirmed R1's pressure ulcer had been identified on 7/2/19. DON reviewed R1's Body Observation Sheets and confirmed the presence of a bleeding sore on 6/25/19. DON confirmed he was not aware of the presence of a bleeding sore on R1 identified 6/25/19, and was not sure why it had been missed. After review of R1's medical record, DON confirmed weekly skin inspections, wound	2 900		

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evaluations had not been completed for R1. He confirmed the last skin assessment had been done in May. DON stated R1 had been admitted to the hospital on 7/18/19, due to symptoms of shaking, whimpering and very diaphoretic. Further, DON stated the hospital informed the facility R1 had sepsis, dehydration and shock and expired on 7/20/19.

On 7/31/19, at 2:19 p.m. NA-E indicated R1's pressure ulcer developed a couple of weeks before R1 was hospitalized. NA-E stated R1's pressure ulcer started out as a tiny spot and within a week R1's pressure ulcer grew larger and started to develop black tissue. NA-E further stated R1's pressure ulcer within the next week or so became larger and developed even more black tissue to it.

On 7/31/19, at 2:33 p.m. during a follow-up interview, DON indicated the facility conducted an ad-hoc meeting that was similar to a root cause analysis after he had been notified of R1's hospitalization and death. DON confirmed no training had been provided to the staff regarding pressure ulcer identification and care since this incident. DON confirmed improvement in processes needed to occur to ensure residents were properly assessed and treated for pressure ulcers in the facility. Additionally, DON confirmed no auditing of cares had been completed and confirmed no changes to the facilty's process for pressure ulcer care had been completed at that time.

Review of physician's progress notes from 5/11/19 to 7/18/19 revealed the following:

-5/11/19, admitted to the facility from home with worsening dementia and significant generalized

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	00583	A. BUILDING: _____ B. WING _____	C 08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW WOODS LLC	601 GRANT AVENUE EVELETH, MN 55734

(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
2 900	Continued From page 15	2 900		

weakness and had a reluctance to walk due to low back pain which was new. Orders for physical therapy, occupational therapy and to continue previous cares. The note had no indication of R1 having any skin concerns at that time.

-6/4/19, physician note indicated the plan was to continue current orders. R1 had no skin issues identified at this visit.

-7/12/19, multiple family members were present for physician visit and had questions about R1's sacral wound as well as her continued urinary issues and dementia. The note indicated the sacral pressure ulcer developed and had progressively worsened due R1 refused to stand or walk or be turned. The plan in the note identified primary physician advised against sending R1 to the hospital for debridement due to outpatient care should be attempted first and indicators of a more systemic issue were not present at the time. New orders were received for nursing staff to insert a urinary catheter due to urinary retention and a significant sacral pressure ulcer. Additionally, new orders were received for R1 to start on antibiotics. The note indicated R1's pressure ulcer was classified as a stage three (full thickness skin loss potentially extending into the subcutaneous tissue) pressure ulcer. Plan was to follow-up in four weeks or sooner if needed.

On 8/1/19, at 9:20 a.m. during a telephone interview, MD-A stated R1's initial discharge plan was to participate in therapy to improve strength and function with the goal of returning home. MD-A stated R1 had dementia and had a fear of standing and falling and as a result was not getting up. MD-A stated during his last visit, R1 was seated in her recliner and appeared very

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2 900	Continued From page 16 uncomfortable. MD-A stated R1's pressure ulcer was pretty big and had a large amount of eschar present. MD-A stated he advised the family they would treat R1's pressure ulcer conservatively. MD-A stated the conservative approach had been attempted for about three days and then the family made the decision to transfer R1 to the hospital. Review of faciltiy policy titled Skin Assessment and Wound Management dated 7/1/18, indicated the staff would complete a Braden scale assessment upon admission, weekly times three and when a significant change occurs. The policy instructed staff to notify licensed staff when skin changes were identified. The policy further instructed licensed staff to complete weekly skin inspections. Additionally, the policy instructed staff to notify the physician, family representative when a pressure ulcer was identified. The policy indicated staff were to initiate the weekly pressure ulcer wound evaluation weekly until healed. The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2018, identified Section M: Skin Conditions to be completed to identify the risk, presence, appearance and change of pressure ulcers/injures. The manual defines a pressure ulcer/injury as a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure in combination of shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful. The manual further identified it was imperative to determine the etiology of all wounds and lesions as that would determine and direct the proper treatment and management of the wound.	2 900		

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2 900	Continued From page 17 - The manual defines an unstageable pressure ulcer/injury as "Known but not stageable due to coverage of wound bed by slough or eschar." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents to determine if at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee could review and revise pressure ulcer policies to ensure identification of pressure ulcers is done, comprehensive assessments and weekly monitoring are completed, and educate staff on those poilicies. The director of nursing or designee, could conduct random audits of the delivery of care; assessments, weekly monitoring to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 900		