DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 18, 2020

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

RE: CCN: 245283
Cycle Start Date: November 4, 2020

Dear Administrator:

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

As authorized by CMS the remedy of:

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

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 Therefore, the NATCEP prohibition is rescinded.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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered
November 24, 2020

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

RE: CCN: 245283
Cycle Start Date: November 4, 2020

Dear Administrator:

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

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 8, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

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

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

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

This Department is also recommending that CMS impose:

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

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

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

If you have not achieved substantial compliance by January 8, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Waterview Pines Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 8, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.
However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient

practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 4, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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 11/04/2020

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
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 11/2/20, through 11/4/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/2/20, through 11/4/20, an abbreviated survey and a COVID-19 Focused Infection Control survey were conducted at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The survey identified the facility was NOT in compliance. The following complaint was substantiated: H5283030C 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.	F 000		

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

Electronically Signed | 12/04/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 580		12/4/20

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F 580	Continued From page 2 (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician of a resident's weight gains as ordered for 1 of 3 residents (R3) reviewed for notification of change. Findings include: R3's Admission Record dated 11/4/20, indicated R3's diagnoses included congestive heart failure (CHF) and chronic kidney disease. R3's significant change Minimum Data Set (MDS) dated 8/28/20, identified R13 had intact cognition. R3's MDS further identified he received diuretic (water pill) medication on seven days. R3's care plan lacked indication daily weights were to be performed. R3's medication administration record (MAR)	F 580	F Tag: F580 Notification Immediate Corrective Action: Resident #3 MD was notified of his weight gain as soon as the discrepancy was identified. Staff identified as having a pattern of not recording a weight for Resident #3 were counseled and re-educated on the importance of obtaining and recording daily weights if ordered and documenting any resident refusals. Corrective Action as it applies to others: The Policy and Procedure for Change in Resident Condition which includes MD notification was reviewed and remains current. All residents were reviewed to assure MD notification with any condition change occurred timely. Condition change will be a focus topic reviewed and discussed at	

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F 580	Continued From page 3 directed the facility was to take daily weights, and notify the heart center if R3's weight increased two pounds in a day, or five pounds in a week. The order was discontinued on 11/4/20. Review of R3's MAR's from 9/1/20, to 11/4/20 revealed following: -R3's weight was noted to increase from 181.4 pounds on 9/4/20, to 185.6 pounds on 9/7/20. It was documented R3 refused to have his weight taken on 9/5/20, and no weight was documented on 9/6/20. -R3's weight was noted to increase from 180.6 pounds on 9/21/20, to 183.8 pounds on 9/22/20. -R3's weight was noted to increase from 179.8 pounds on 10/7/20, to 184.4 pounds on 10/8/20. -R3's weight was noted to increase from 177.6 pounds on 10/27/20, to 181 pounds on 10/31/20. It was documented R3 refused to have his weight taken on 10/28/20, and no weights were documented on 10/29/20, and 10/30/20. Review of R3's medical record lacked indication the heart center physician was notified of R3's weight increases on the above dates. On 11/3/20, at 3:16 p.m. an interview was conducted with R3. R3 stated he believed facility staff didn't forgot to take his weight. R3 stated he didn't refuse to have his weight taken as "everything to do with my health is important." On 11/3/20, at 3:18 p.m. an interview was conducted with nursing assistant (NA)-B. NA-B stated R3 was to have his weight taken daily. NA-B stated weights were documented in the electronic medical record (eMR).	F 580	morning stand-up. All nursing staff will be re-educated on the Change in Resident Condition Policy and the need to notify MD timely, document any resident treatment refusals and notify their supervisor. Date of Compliance: 12/4/2020 Recurrence will be prevented by: All residents with any condition change will be reviewed weekly x 4 weekly then monthly x 2 months to assure MD notification occurred, documentation is present, refusals documented and supervisor notified. 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/Unit Managers	

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F 580	Continued From page 4	F 580		

On 11/4/20, at 11:09 a.m. an interview was conducted with licensed practical nurse (LPN)-C. LPN-C stated R3 was to have his weight taken daily, however, sometimes he refused. LPN-C stated nursing compared the weight provided by the NAs to the last documented weight in a resident's record.

On 11/4/20, at 11:19 a.m. an interview was conducted with registered nurse (RN)-B. RN-B confirmed R3 was ordered to have his weight taken daily. RN-B reviewed R3's medical record and confirmed documentation of weights were missing. RN-B stated there was likely instances where a weight was not obtained and subsequently not communicated to the next shift. RN-B stated she was unsure why weights were not taken, however, verbalized there appeared to be "repeat offenders" on the dates in which weights were not documented. RN-B stated R3 was not known to refuse having his weight taken. RN-B confirmed R3's physician was to be notified of a two pound weight increase in a day. RN-B stated, "If it's not documented, it is not done" regarding physician notification. RN-B stated R3's physician should had also be notified when weights were not taken, and R3 had a weight increased.

On 11/4/20, at 12:45 p.m. an interview was conducted with the director of nursing (DON). The DON stated two staff were identified as being "offenders" regarding R3's weights. The DON stated one staff-person was already reeducated. The DON stated staff were expected to obtain weights, as ordered, or document refusals. The DON stated if a resident refused, a risk versus benefits document needed to be completed. The DON stated staff were expected to update the

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F 580	Continued From page 5 physician when a resident had a weight gain as there was a risk for fluid overload. The facility policy Change in Resident Condition dated 6/19, directed, "The facility shall notify the resident/representative and physician/healthcare provider of changes in the resident's condition and/or status."	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct follow-up assessments and monitor blood pressures for 1 of 3 residents (R1) who was hypotensive (had low blood pressure). In addition, the facility failed to obtain daily weights for 1 of 3 residents (R3). Findings include: Assessment/Blood Pressure R1's Admission Record dated 11/4/20, indicated R1's diagnoses included heart failure, atrial fibrillation (irregular heart rhythm), and hypertension.	F 684	F Tag: F684 Quality of Care Immediate Corrective Action: Immediate education for all licensed nurses began on 11/3/2020 regarding the need for follow up assessments when a resident was hypotensive as was displayed by Resident #1. Resident #3 MD was notified of his weight gain as soon as the discrepancy was identified. Staff identified as having a pattern of not recording a weight for Resident #3 were counseled and re-educated on the importance of obtaining and recording daily weights if ordered and documenting any resident refusals.	12/4/20

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F 684	Continued From page 6 R1's admission Minimum Data Set (MDS) dated 8/18/20, identified R1 had intact cognition. R1's Medication Administration Record (MAR) dated 9/1/20, to 9/30/20, directed encourage fluid intake, every shift, as blood pressure was low. R1's ADL (activities of daily living) Functional / Rehabilitation Potential Care Area Assessment (CAA) dated 8/20/20, indicated R1 was working with therapy to improve her strength and overall functional abilities. The CAA further indicated R1's initial plan was to be discharged home, however, safety and cognition were potential barriers. R1's care plan dated 8/26/20, indicated R1 had an alteration in hematological (blood) status. The care plan directed to give medications, as ordered, and monitor for side effects/effectiveness. Review of R1's blood pressures revealed the following: - R1's blood pressure was documented as 76/46 on 9/9/20, at 10:27 p.m. - R1's blood pressure was documented as 88/54 on 9/9/20, at 11:14 p.m. - R1's blood pressure was documented as 92/72 on 9/10/20, at 3:01 a.m. - No blood pressures were documented from 9/11/20, to 9/13/20. - R1's blood pressure was documented as 70/40 on 9/14/20, at 12:55 p.m. A progress note dated 9/11/20, at 5:55 p.m. indicated R1 had a telehealth visit with her physician for a "rash under her left breast." The progress note further indicated there were, "No	F 684	Corrective Action as it applies to others: The Policy and Procedure for Change in Resident Condition was reviewed and remains current. The Policy and Procedure for Resident Weight Evaluation was reviewed and remains current. All residents were reviewed to assure MD notification with any condition change occurred timely, as well as completion of any follow-up assessments indicated, documentation of any treatment refusals is present and notification of supervisor of condition changes or treatment refusals. Condition change will be a focus topic reviewed and discussed at morning stand-up. All nursing staff will be re-educated on the Change in Resident Condition Policy and the Resident Weight Evaluation Policy and the need to notify MD timely, initiate any follow-up assessments, document any resident treatment refusals and notify their supervisor for condition changes or treatment refusals. Date of Compliance: 12/4/2020 Recurrence will be prevented by: All residents with any condition change will be reviewed weekly x 4 weeks then monthly x 2 months to assure MD notification occurred, follow-up assessments are initiated, documentation is present, refusals documented and supervisor notified. 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/Unit Managers	

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other concerns at this time."

A document titled Essentia Health - Virginia Elder Care dated 9/11/20, indicated a telemedicine consultation was completed with R1's physician. The document indicated nursing reported R1's cognition was "rather poor." The document further indicated R1 "was not drinking a lot" and her blood pressures were 88/54, 76/46, and 92/72. Nursing was "going to push fluids a bit to see if helps." R1 reported feeling "fine."

A progress note dated 9/14/20, at 12:56 p.m. indicated R1 was "very lethargic" and was unable to stand independently "as she had been doing." R1 was unable to keep her eyes open to answer questions. R1's vital signs indicated her blood pressure was "low." R1's physician was notified and an order was obtained to send R1 to the emergency department. R1's daughter was standing outside of R1's window.

A progress note dated 9/14/20, at 1:00 p.m. indicated R1's representative updated the facility R1 was septic (severe infection) and R1's urine was "bad." The progress note further indicated R1's representative stated R1 was talkative and visited with family on 9/12/20, however, only answered "yes and no" questions on 9/13/20.

Review of R1's medical record lacked indication follow-up assessments were conducted from 9/11/20, to 9/13/20.

On 11/2/20, at 4:12 p.m. an interview was conducted with licensed practical nurse (LPN)-A. LPN-A stated sometimes R1 was "clear" and other times she wasn't. LPN-A stated she did not recall R1 had a low blood pressure or change of

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condition.

On 11/3/20, at 12:26 p.m. an interview was conducted with family member (F)-A. F-A stated R1 tripped on a carpet and suffered a T11 (vertebrae) fracture prior to admission to the facility. F-A stated R1 was admitted to the facility for bedrest and therapy. F-A stated her sister spoke to R1 on 9/12/20, and R1 was "doing fine." F-A stated sometime between 9/12/20, and 9/14/20, "Something happened to her [R1]." F-A stated she received a call on 9/14/20, and was told R1 was going to be sent to the emergency department. F-A stated she went to the facility and looked through R1's window. F-A stated R1 was unable to hang onto a phone because she was "weak" and "looked gray." F-A stated R1 was moaning. F-A stated she stood outside of R1's window for three to five minutes and no staff were in R1's room. F-A stated she called registered nurse (RN)-A and she was informed R1's blood pressure was "really low." F-A stated three people then came to R1's room "very quickly." F-A stated she then left to meet R1 at the hospital. F-A stated once at the hospital, the physician told her R1 was not expected to survive, and R1 looked like she was dying. F-A stated she was told R1's blood pressure was 50/47. F-A stated R1 had a catheter placed and R1's urine looked like "creamed corn." F-A stated R1 had a lack of oxygen to her brain and was severely dehydrated. F-A stated R1 had since been discharged from the hospital and was admitted to hospice services.

On 11/3/20, at 3:09 p.m. an interview was conducted with LPN-B. LPN-B stated R1 refused a lot of cares and was a "confused lady." LPN-B stated R1 "slept a lot" and did not recall a change

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in condition for R1. LPN-B stated she would report a low blood pressure reading to her unit manager and encourage a resident to drink fluids. LPN-B stated she would reassess a resident, who had a low blood pressure, every 15 minutes.

On 11/3/20, at 3:27 p.m., an interview was conducted with registered nurse (RN)-A. RN-A stated R1 was admitted to the facility for short-term rehabilitation. RN-A stated R1 was a "very independent lady" and told staff not to "bug" her. RN-A stated cognitive testing was conducted on R1, and it was determined R1 had dementia. RN-A stated she was informed on 9/14/20, "something was wrong" with R1. RN-A stated R1 was lethargic, however, R1 verbalized she was "fine." RN-A stated R1's daughter was at R1's window at this time. RN-A stated R1 needed to be sent out because she was not as alert as she previously was. RN-A stated she left R1's room, obtained a bed hold form, and returned and found R1's was speaking "gibberish." RN-A stated R1 was transferred to the hospital, and R1's daughter later called and stated R1 had a "bad" urinary tract infection. RN-A stated R1's family informed her R1 was "really talkative" on 9/12/20, however, R1 was unable to hold a telephone on 9/13/20. RN-A stated she spoke with staff who worked on 9/13/20, and nurse told her R1 didn't seem like her "old self" and R1 was "sleepier." RN-A stated she was unable to recall who the nurse was. RN-A stated she "vaguely" remembered speaking to R1's physician on 9/11/20, and being told to push fluids due to low blood pressure readings. RN-A stated the frequency of blood pressure monitoring was dependent upon readings. RN-A stated if a resident's blood pressure was less than 100 she would expect the charge nurse to be updated.

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RN-A stated staff "probably" should had followed R1's blood pressure more closely.

On 11/4/20, at 12:45 p.m. an interview was conducted with the director of nursing (DON). The DON stated staff were expected to conduct follow-up assessments when abnormal values were identified. The DON stated a corporate consultant had reviewed R1's medical record and determined staff needed to recheck R1's blood pressures, and update the medical provider. The DON stated R1 was "good" on 9/12/20, however, it was reported R1 was "sleepy" on 9/13/20. The DON stated "most" nurses' were educated on change of condition and what sepsis looked like. The DON stated staff should not wait to talk to the RN or leave a note for the clinical manager when a resident had a change of condition. The DON stated staff education was started on 11/3/20.

The facility policy Change in Resident Condition dated 6/19, directed, "Prior to notifying the physician/healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider."

Weights

R3's Admission Record, dated 11/4/20, indicated R3's diagnoses included congestive heart failure (CHF) and chronic kidney disease.

R3's significant change MDS dated 8/28/20, identified R3 had intact cognition. R3's MDS further identified he received diuretic medication (water pill) on seven days.

R3's care plan lacked indication daily weights were to be performed.

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R3's medication administration record (MAR) directed R3 was to have his weight taken daily due to CHF. The order was discontinued on 11/4/20. Review of R3's MAR's from 9/1/20, to 11/4/20, revealed following:

-No weights were documented on 9/3/20, 9/6/20, 9/10/20, 9/11/20, 9/12/20, 9/13/20, 9/18/20, 9/19/20/ 9/23/20, 9/26/20, 9/29/20,10/6/20, 10/14/20, 10/16/20, 10/17/20, 10/20/20, 10/21/20, 10/22/20, 10/25/20, 10/29/20,10/30/20, 11/1/20, and 11/3/20.
-Weights were documented as refused on 9/5/20, 9/9/20, 9/20/20, 10/15/20 and 10/28/20.

On 11/3/20, at 3:16 p.m. an interview was conducted with R3. R3 stated he believed facility staff didn't forgot to take his weight. R3 stated he didn't refuse to have his weight taken as "everything to do with my health is important."

On 11/3/20, at 3:18 p.m. an interview was conducted with NA-B. NA-B stated R3 was to have his weight taken daily. NA-B stated weights were documented in the electronic medical record (eMR).

On 11/4/20, at 11:09 a.m. an interview was conducted with LPN-C. LPN-C stated R3 was to have his weight taken daily, however, sometimes he refused.

On 11/4/20, at 11:19 a.m. an interview was conducted with RN-B. RN-B confirmed R3 was ordered to have his weight taken daily. RN-B reviewed R3's medical record and confirmed documentation of weights were missing. RN-B stated there was likely instances where a weight

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F 684	Continued From page 12 was not obtained and subsequently not communicated to the next shift. RN-B she was unsure why weights were not taken, however, verbalized there appeared to be "repeat offenders" on the dates in which weights were not documented. RN-B stated R3 was not known to refuse having his weight taken. On 11/4/20, at 12:45 p.m., an interview was conducted with the DON. The DON stated two staff were identified as being "offenders" regarding R3's weights. The DON stated one staff-person was already reeducated. The DON stated staff were expected to obtain weights, as ordered, or document refusals. The DON stated if a resident refused, a risk versus benefits document needed to be completed. The facility policy Resident Weight Evaluation dated 9/12, directed, "It is the policy of all Monarch Healthcare Management Rehabilitation facilities to obtain an accurate weight of residents upon admission or readmission. Further, weights shall be done for each resident monthly or more often according to the physician's order, or a consensus between the interdisciplinary team."	F 684		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		12/4/20

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program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 14 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure hand hygiene was completed during incontinence cares to prevent cross contamination for 1 of 3 residents (R5) reviewed for bowel and bladder incontinence. Findings include: R5's Diagnoses Report dated 11/4/20, indicated R5's diagnoses included dementia with behavioral disturbance. R5's quarterly Minimum Data Set (MDS) dated 10/8/20, identified R5 had severely impaired cognition. R5's MDS further identified she was totally dependent upon staff for toileting, and was always incontinent of bowel and bladder. R5's care plan dated 7/12/20, indicated R5 experienced bowel and bladder incontinence. The	F 880	F Tag: F880 DPOC Immediate Corrective Action: NA-C was counseled and re-educated with return demonstration competency on the Hand Hygiene Policy on 11/4/2020. Corrective Action as it applies to others: All residents have the potential to be affected by the deficient practice. The facility QAPI Committee conducted a Root Cause Analysis of the deficient practice and developed a corrective action plan to prevent recurrence. The Policy and Procedure for proper Hand Hygiene was reviewed and remains current with CDC guidelines. All staff to include the DON and Infection Preventionist will receive re-education on the Hand Hygiene Policy and Procedure, Transmission based precautions and caring for and disinfecting medical	

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F 880	Continued From page 15 care plan directed staff to provide incontinence care after each incontinent episode. On 11/4/20, at 10:39 a.m. nursing assistant (NA)-C entered R5's room, provided privacy, and put on a pair of gloves. NA-C transferred R5 from a wheelchair to a bed, using a mechanical ceiling lift. NA-C lowered R5's pants and unfastened R5's soiled incontinence product. NA-C grabbed wet wipes, cleaned R5's groin area, and disposed of the wet wipes in a garbage can. NA-C stated R5 was "wet," and encouraged R5 to reach for a side rail. NA-C pushed on R5's back and rolled R5 to her left side. NA-C used an exposed portion of R5's soiled incontinence product to wipe stool off of R5's buttocks. NA-C then partially rolled R5's soiled incontinence product, and pulled it out from under R5. The soiled incontinence product remained on R5's bed. NA-C obtained additional wet wipes, cleaned R5's buttocks, and placed each wet wipe on the soiled incontinence product which was on R5's bed. NA-C disposed of the soiled incontinence product in a garbage. Without changing gloves or performing hand hygiene, NA-C obtained a clean incontinence product and partially placed it under R5. NA-C instructed R5 to roll on her back and R5 let go of the bed rail. NA-C touched R5's blue sweater near R5's right shoulder, and briefly held R5's right hand with her soiled gloved hand. NA-C walked to R5's left side and assisted R5 roll to her right side by pushing on her back with her soiled gloved hands. NA-C pulled the clean incontinence product from under R5, and pulled down R5's blue sweater with her soiled gloved hands. R5 again rolled to her back. NA-C reached for the package of wet wipes and stated, "I would like another pair of gloves." NA-C did not perform hand hygiene or obtain new	F 880	equipment. Resources from CDC and MDH will be utilized for the re-education. The DON, Infection Preventionist and Clinical Education Coordinator will conduct return demonstration competencies on proper hand hygiene with all staff and maintain a log with results. Date of Compliance: 12/4/2020 Recurrence will be prevented by: The DON, Infection Preventionist and other leadership staff will conduct audits on all shifts, every day for one week to assure proper infection control practices are being followed including hand hygiene. The results of the audits will be shared with the facility QAPI Committee and based on the results, the audits will continue daily or decrease in numbers and be discontinued once 100% compliance is demonstrated. Corrections will be monitored by: DON and Infection Preventionist	

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gloves. R5 grabbed additional wet wipes and wiped R5's inner thighs. NA-C started to fasten R5's incontinence product. At 10:52 a.m. the director of nursing (DON) entered R5's room. The DON instructed NA-C to remove her gloves, clean her hands, and to put clean gloves on. NA-C walked to R5's bathroom, washed her hands, and returned to R5 with additional pairs of gloves. NA-C stated, "I should have done this in the first place." NA-C finished fastening R5's incontinence product, and R5 was rolled side-to-side and her pants were raised. The DON instructed NA-C to remove her gloves and again wash her hands.

On 11/4/20, at 11:07 a.m. an interview was conducted with registered nurse (RN)-B. RN-B stated hand hygiene needed to be completed after performing incontinence cares. RN-B stated there was a risk for contamination if staff failed to perform hand hygiene.

On 11/4/20, at 11:22 a.m. an interview was conducted with NA-C. NA-C confirmed she needed to perform hand hygiene and put on new gloves after she performed incontinence cares on R5. NA-C stated she was "nervous."

On 11/4/20, at 12:45 p.m. an interview was conducted with the DON. The DON stated staff were expected to wash their hands and change their gloves when moving from a dirty area to a clean area during resident care. The DON stated it was an infection control risk.

The facility policy Hand Hygiene dated 6/17, directed hand hygiene needed to be completed, "After contact with a resident's mucous membranes and body fluids or excretions."

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 24, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: XH1Q11

Dear Administrator:

The above facility was surveyed on November 2, 2020 through November 4, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is 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:

Teresa Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

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 11/04/2020

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/2/20, through 11/4/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5283030C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. On 11/2/20, through 11/4/20, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;	2 265		12/4/20

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2 265	Continued From page 2 C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician of a resident's weight gains as ordered for 1 of 3 residents (R3) reviewed for notification of change. Findings include: R3's Admission Record dated 11/4/20, indicated R3's diagnoses included congestive heart failure (CHF) and chronic kidney disease. R3's significant change Minimum Data Set (MDS) dated 8/28/20, identified R13 had intact cognition. R3's MDS further identified he received diuretic (water pill) medication on seven days. R3's care plan lacked indication daily weights were to be performed. R3's medication administration record (MAR) directed the facility was to take daily weights, and notify the heart center if R3's weight increased two pounds in a day, or five pounds in a week. The order was discontinued on 11/4/20. Review of R3's MAR's from 9/1/20, to 11/4/20 revealed following:	2 265	F Tag: F580 Notification Immediate Corrective Action: Resident #3 MD was notified of his weight gain as soon as the discrepancy was identified. Staff identified as having a pattern of not recording a weight for Resident #3 were counseled and re-educated on the importance of obtaining and recording daily weights if ordered and documenting any resident refusals. Corrective Action as it applies to others: The Policy and Procedure for Change in Resident Condition which includes MD notification was reviewed and remains current. All residents were reviewed to assure MD notification with any condition change occurred timely. Condition change will be a focus topic reviewed and discussed at morning stand-up. All nursing staff will be re-educated on the Change in Resident Condition Policy and the need to notify MD timely, document any resident treatment refusals and notify their supervisor.	

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2 265	Continued From page 3 -R3's weight was noted to increase from 181.4 pounds on 9/4/20, to 185.6 pounds on 9/7/20. It was documented R3 refused to have his weight taken on 9/5/20, and no weight was documented on 9/6/20. -R3's weight was noted to increase from 180.6 pounds on 9/21/20, to 183.8 pounds on 9/22/20. -R3's weight was noted to increase from 179.8 pounds on 10/7/20, to 184.4 pounds on 10/8/20. -R3's weight was noted to increase from 177.6 pounds on 10/27/20, to 181 pounds on 10/31/20. It was documented R3 refused to have his weight taken on 10/28/20, and no weights were documented on 10/29/20, and 10/30/20. Review of R3's medical record lacked indication the heart center physician was notified of R3's weight increases on the above dates. On 11/3/20, at 3:16 p.m. an interview was conducted with R3. R3 stated he believed facility staff didn't forgot to take his weight. R3 stated he didn't refuse to have his weight taken as "everything to do with my health is important." On 11/3/20, at 3:18 p.m. an interview was conducted with nursing assistant (NA)-B. NA-B stated R3 was to have his weight taken daily. NA-B stated weights were documented in the electronic medical record (eMR). On 11/4/20, at 11:09 a.m. an interview was conducted with licensed practical nurse (LPN)-C. LPN-C stated R3 was to have his weight taken daily, however, sometimes he refused. LPN-C stated nursing compared the weight provided by the NAs to the last documented weight in a resident's record.	2 265	Date of Compliance: 12/4/2020 Recurrence will be prevented by: All residents with any condition change will be reviewed weekly x 4 weekly then monthly x 2 months to assure MD notification occurred, documentation is present, refusals documented and supervisor notified. 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/Unit Managers	

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2 265	Continued From page 4 On 11/4/20, at 11:19 a.m. an interview was conducted with registered nurse (RN)-B. RN-B confirmed R3 was ordered to have his weight taken daily. RN-B reviewed R3's medical record and confirmed documentation of weights were missing. RN-B stated there was likely instances where a weight was not obtained and subsequently not communicated to the next shift. RN-B stated she was unsure why weights were not taken, however, verbalized there appeared to be "repeat offenders" on the dates in which weights were not documented. RN-B stated R3 was not known to refuse having his weight taken. RN-B confirmed R3's physician was to be notified of a two pound weight increase in a day. RN-B stated, "If it's not documented, it is not done" regarding physician notification. RN-B stated R3's physician should had also be notified when weights were not taken, and R3 had a weight increased. On 11/4/20, at 12:45 p.m. an interview was conducted with the director of nursing (DON). The DON stated two staff were identified as being "offenders" regarding R3's weights. The DON stated one staff-person was already reeducated. The DON stated staff were expected to obtain weights, as ordered, or document refusals. The DON stated if a resident refused, a risk versus benefits document needed to be completed. The DON stated staff were expected to update the physician when a resident had a weight gain as there was a risk for fluid overload. The facility policy Change in Resident Condition dated 6/19, directed, "The facility shall notify the resident/representative and physician/healthcare provider of changes in the resident's condition and/or status."	2 265		

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2 265	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), or designee, could develop, review, and/or revise policies and procedures to ensure residents/family representatives/physicians are notified of a change in condition or treatment. The DON, or designee, could educate all appropriate staff on the policies and procedures. The DON, or designee, could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to conduct follow-up assessments and monitor blood pressures for 1 of 3 residents (R1) who was hypotensive (had low blood	2 830	F Tag: F684 Quality of Care Immediate Corrective Action: Immediate education for all licensed nurses began on 11/3/2020 regarding the	12/4/20

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2 830	Continued From page 6 pressure). In addition, the facility failed to obtain daily weights for 1 of 3 residents (R3). Findings include: Assessment/Blood Pressure R1's Admission Record dated 11/4/20, indicated R1's diagnoses included heart failure, atrial fibrillation (irregular heart rhythm), and hypertension. R1's admission Minimum Data Set (MDS) dated 8/18/20, identified R1 had intact cognition. R1's Medication Administration Record (MAR) dated 9/1/20, to 9/30/20, directed encourage fluid intake, every shift, as blood pressure was low. R1's ADL (activities of daily living) Functional / Rehabilitation Potential Care Area Assessment (CAA) dated 8/20/20, indicated R1 was working with therapy to improve her strength and overall functional abilities. The CAA further indicated R1's initial plan was to be discharged home, however, safety and cognition were potential barriers. R1's care plan dated 8/26/20, indicated R1 had an alteration in hematological (blood) status. The care plan directed to give medications, as ordered, and monitor for side effects/effectiveness. Review of R1's blood pressures revealed the following: - R1's blood pressure was documented as 76/46 on 9/9/20, at 10:27 p.m. - R1's blood pressure was documented as 88/54 on 9/9/20, at 11:14 p.m.	2 830	need for follow up assessments when a resident was hypotensive as was displayed by Resident #1. Resident #3 MD was notified of his weight gain as soon as the discrepancy was identified. Staff identified as having a pattern of not recording a weight for Resident #3 were counseled and re-educated on the importance of obtaining and recording daily weights if ordered and documenting any resident refusals. Corrective Action as it applies to others: The Policy and Procedure for Change in Resident Condition was reviewed and remains current. The Policy and Procedure for Resident Weight Evaluation was reviewed and remains current. All residents were reviewed to assure MD notification with any condition change occurred timely, as well as completion of any follow-up assessments indicated, documentation of any treatment refusals is present and notification of supervisor of condition changes or treatment refusals. Condition change will be a focus topic reviewed and discussed at morning stand-up. All nursing staff will be re-educated on the Change in Resident Condition Policy and the Resident Weight Evaluation Policy and the need to notify MD timely, initiate any follow-up assessments, document any resident treatment refusals and notify their supervisor for condition changes or treatment refusals. Date of Compliance: 12/4/2020 Recurrence will be prevented by: All residents with any condition change will be reviewed weekly x 4 weeks then	

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2 830	Continued From page 7 - R1's blood pressure was documented as 92/72 on 9/10/20, at 3:01 a.m. - No blood pressures were documented from 9/11/20, to 9/13/20. - R1's blood pressure was documented as 70/40 on 9/14/20, at 12:55 p.m. A progress note dated 9/11/20, at 5:55 p.m. indicated R1 had a telehealth visit with her physician for a "rash under her left breast." The progress note further indicated there were, "No other concerns at this time." A document titled Essentia Health - Virginia Elder Care dated 9/11/20, indicated a telemedicine consultation was completed with R1's physician. The document indicated nursing reported R1's cognition was "rather poor." The document further indicated R1 "was not drinking a lot" and her blood pressures were 88/54, 76/46, and 92/72. Nursing was "going to push fluids a bit to see if helps." R1 reported feeling "fine." A progress note dated 9/14/20, at 12:56 p.m. indicated R1 was "very lethargic" and was unable to stand independently "as she had been doing." R1 was unable to keep her eyes open to answer questions. R1's vital signs indicated her blood pressure was "low." R1's physician was notified and an order was obtained to send R1 to the emergency department. R1's daughter was standing outside of R1's window. A progress note dated 9/14/20, at 1:00 p.m. indicated R1's representative updated the facility R1 was septic (severe infection) and R1's urine was "bad." The progress note further indicated R1's representative stated R1 was talkative and visited with family on 9/12/20, however, only answered "yes and no" questions on 9/13/20.	2 830	monthly x 2 months to assure MD notification occurred, follow-up assessments are initiated, documentation is present, refusals documented and supervisor notified. 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/Unit Managers	

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2 830	Continued From page 8 Review of R1's medical record lacked indication follow-up assessments were conducted from 9/11/20, to 9/13/20. On 11/2/20, at 4:12 p.m. an interview was conducted with licensed practical nurse (LPN)-A. LPN-A stated sometimes R1 was "clear" and other times she wasn't. LPN-A stated she did not recall R1 had a low blood pressure or change of condition. On 11/3/20, at 12:26 p.m. an interview was conducted with family member (F)-A. F-A stated R1 tripped on a carpet and suffered a T11 (vertebrae) fracture prior to admission to the facility. F-A stated R1 was admitted to the facility for bedrest and therapy. F-A stated her sister spoke to R1 on 9/12/20, and R1 was "doing fine." F-A stated sometime between 9/12/20, and 9/14/20, "Something happened to her [R1]." F-A stated she received a call on 9/14/20, and was told R1 was going to be sent to the emergency department. F-A stated she went to the facility and looked through R1's window. F-A stated R1 was unable to hang onto a phone because she was "weak" and "looked gray." F-A stated R1 was moaning. F-A stated she stood outside of R1's window for three to five minutes and no staff were in R1's room. F-A stated she called registered nurse (RN)-A and she was informed R1's blood pressure was "really low." F-A stated three people then came to R1's room "very quickly." F-A stated she then left to meet R1 at the hospital. F-A stated once at the hospital, the physician told her R1 was not expected to survive, and R1 looked like she was dying. F-A stated she was told R1's blood pressure was 50/47. F-A stated R1 had a catheter placed and R1's urine looked like "creamed corn." F-A stated	2 830		

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2 830	Continued From page 9 R1 had a lack of oxygen to her brain and was severely dehydrated. F-A stated R1 had since been discharged from the hospital and was admitted to hospice services. On 11/3/20, at 3:09 p.m. an interview was conducted with LPN-B. LPN-B stated R1 refused a lot of cares and was a "confused lady." LPN-B stated R1 "slept a lot" and did not recall a change in condition for R1. LPN-B stated she would report a low blood pressure reading to her unit manager and encourage a resident to drink fluids. LPN-B stated she would reassess a resident, who had a low blood pressure, every 15 minutes. On 11/3/20, at 3:27 p.m., an interview was conducted with registered nurse (RN)-A. RN-A stated R1 was admitted to the facility for short-term rehabilitation. RN-A stated R1 was a "very independent lady" and told staff not to "bug" her. RN-A stated cognitive testing was conducted on R1, and it was determined R1 had dementia. RN-A stated she was informed on 9/14/20, "something was wrong" with R1. RN-A stated R1 was lethargic, however, R1 verbalized she was "fine." RN-A stated R1's daughter was at R1's window at this time. RN-A stated R1 needed to be sent out because she was not as alert as she previously was. RN-A stated she left R1's room, obtained a bed hold form, and returned and found R1's was speaking "gibberish." RN-A stated R1 was transferred to the hospital, and R1's daughter later called and stated R1 had a "bad" urinary tract infection. RN-A stated R1's family informed her R1 was "really talkative" on 9/12/20, however, R1 was unable to hold a telephone on 9/13/20. RN-A stated she spoke with staff who worked on 9/13/20, and nurse told her R1 didn't seem like her "old self" and R1 was "sleepier." RN-A stated she was unable to recall who the	2 830		

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2 830	Continued From page 10	2 830		

nurse was. RN-A stated she "vaguely" remembered speaking to R1's physician on 9/11/20, and being told to push fluids due to low blood pressure readings. RN-A stated the frequency of blood pressure monitoring was dependent upon readings. RN-A stated if a resident's blood pressure was less than 100 she would expect the charge nurse to be updated. RN-A stated staff "probably" should had followed R1's blood pressure more closely.

On 11/4/20, at 12:45 p.m. an interview was conducted with the director of nursing (DON). The DON stated staff were expected to conduct follow-up assessments when abnormal values were identified. The DON stated a corporate consultant had reviewed R1's medical record and determined staff needed to recheck R1's blood pressures, and update the medical provider. The DON stated R1 was "good" on 9/12/20, however, it was reported R1 was "sleepy" on 9/13/20. The DON stated "most" nurses' were educated on change of condition and what sepsis looked like. The DON stated staff should not wait to talk to the RN or leave a note for the clinical manager when a resident had a change of condition. The DON stated staff education was started on 11/3/20.

The facility policy Change in Resident Condition dated 6/19, directed, "Prior to notifying the physician/healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider."

Weights

R3's Admission Record, dated 11/4/20, indicated R3's diagnoses included congestive heart failure (CHF) and chronic kidney disease.

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2 830	Continued From page 11 R3's significant change MDS dated 8/28/20, identified R3 had intact cognition. R3's MDS further identified he received diuretic medication (water pill) on seven days. R3's care plan lacked indication daily weights were to be performed. R3's medication administration record (MAR) directed R3 was to have his weight taken daily due to CHF. The order was discontinued on 11/4/20. Review of R3's MAR's from 9/1/20, to 11/4/20, revealed following: -No weights were documented on 9/3/20, 9/6/20, 9/10/20, 9/11/20, 9/12/20, 9/13/20, 9/18/20, 9/19/20/ 9/23/20, 9/26/20, 9/29/20,10/6/20, 10/14/20, 10/16/20, 10/17/20, 10/20/20, 10/21/20, 10/22/20, 10/25/20, 10/29/20,10/30/20, 11/1/20, and 11/3/20. -Weights were documented as refused on 9/5/20, 9/9/20, 9/20/20, 10/15/20 and 10/28/20. On 11/3/20, at 3:16 p.m. an interview was conducted with R3. R3 stated he believed facility staff didn't forgot to take his weight. R3 stated he didn't refuse to have his weight taken as "everything to do with my health is important." On 11/3/20, at 3:18 p.m. an interview was conducted with NA-B. NA-B stated R3 was to have his weight taken daily. NA-B stated weights were documented in the electronic medical record (eMR). On 11/4/20, at 11:09 a.m. an interview was conducted with LPN-C. LPN-C stated R3 was to have his weight taken daily, however, sometimes he refused.	2 830		

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2 830	Continued From page 12 On 11/4/20, at 11:19 a.m. an interview was conducted with RN-B. RN-B confirmed R3 was ordered to have his weight taken daily. RN-B reviewed R3's medical record and confirmed documentation of weights were missing. RN-B stated there was likely instances where a weight was not obtained and subsequently not communicated to the next shift. RN-B she was unsure why weights were not taken, however, verbalized there appeared to be "repeat offenders" on the dates in which weights were not documented. RN-B stated R3 was not known to refuse having his weight taken. On 11/4/20, at 12:45 p.m., an interview was conducted with the DON. The DON stated two staff were identified as being "offenders" regarding R3's weights. The DON stated one staff-person was already reeducated. The DON stated staff were expected to obtain weights, as ordered, or document refusals. The DON stated if a resident refused, a risk versus benefits document needed to be completed. The facility policy Resident Weight Evaluation dated 9/12, directed, "It is the policy of all Monarch Healthcare Management Rehabilitation facilities to obtain an accurate weight of residents upon admission or readmission. Further, weights shall be done for each resident monthly or more often according to the physician's order, or a consensus between the interdisciplinary team." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could develop or revise policies/procedures related to resident assessment and implementation of physician orders. The DON, or designee, could train staff in implementation of policy, care plans, and physician orders. The DON, or designee,	2 830		

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2 830	Continued From page 13 could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure hand hygiene was completed during incontinence cares to prevent cross contamination for 1 of 3 residents (R5) reviewed for bowel and bladder incontinence. Findings include: R5's Diagnoses Report dated 11/4/20, indicated R5's diagnoses included dementia with behavioral disturbance. R5's quarterly Minimum Data Set (MDS) dated 10/8/20, identified R5 had severely impaired cognition. R5's MDS further identified she was totally dependent upon staff for toileting, and was always incontinent of bowel and bladder. R5's care plan dated 7/12/20, indicated R5 experienced bowel and bladder incontinence. The care plan directed staff to provide incontinence	21375	F Tag: F880 DPOC Immediate Corrective Action: NA-C was counseled and re-educated with return demonstration competency on the Hand Hygiene Policy on 11/4/2020. Corrective Action as it applies to others: All residents have the potential to be affected by the deficient practice. The facility QAPI Committee conducted a Root Cause Analysis of the deficient practice and developed a corrective action plan to prevent recurrence. The Policy and Procedure for proper Hand Hygiene was reviewed and remains current with CDC guidelines. All staff to include the DON and Infection Preventionist will receive re-education on the Hand Hygiene Policy and Procedure, Transmission based precautions and caring for and disinfecting medical equipment. Resources from CDC and	12/4/20

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21375	Continued From page 14 care after each incontinent episode. On 11/4/20, at 10:39 a.m. nursing assistant (NA)-C entered R5's room, provided privacy, and put on a pair of gloves. NA-C transferred R5 from a wheelchair to a bed, using a mechanical ceiling lift. NA-C lowered R5's pants and unfastened R5's soiled incontinence product. NA-C grabbed wet wipes, cleaned R5's groin area, and disposed of the wet wipes in a garbage can. NA-C stated R5 was "wet," and encouraged R5 to reach for a side rail. NA-C pushed on R5's back and rolled R5 to her left side. NA-C used an exposed portion of R5's soiled incontinence product to wipe stool off of R5's buttocks. NA-C then partially rolled R5's soiled incontinence product, and pulled it out from under R5. The soiled incontinence product remained on R5's bed. NA-C obtained additional wet wipes, cleaned R5's buttocks, and placed each wet wipe on the soiled incontinence product which was on R5's bed. NA-C disposed of the soiled incontinence product in a garbage. Without changing gloves or performing hand hygiene, NA-C obtained a clean incontinence product and partially placed it under R5. NA-C instructed R5 to roll on her back and R5 let go of the bed rail. NA-C touched R5's blue sweater near R5's right shoulder, and briefly held R5's right hand with her soiled gloved hand. NA-C walked to R5's left side and assisted R5 roll to her right side by pushing on her back with her soiled gloved hands. NA-C pulled the clean incontinence product from under R5, and pulled down R5's blue sweater with her soiled gloved hands. R5 again rolled to her back. NA-C reached for the package of wet wipes and stated, "I would like another pair of gloves." NA-C did not perform hand hygiene or obtain new gloves. R5 grabbed additional wet wipes and wiped R5's inner thighs. NA-C started to fasten	21375	MDH will be utilized for the re-education. The DON, Infection Preventionist and Clinical Education Coordinator will conduct return demonstration competencies on proper hand hygiene with all staff and maintain a log with results. Date of Compliance: 12/4/2020 Recurrence will be prevented by: The DON, Infection Preventionist and other leadership staff will conduct audits on all shifts, every day for one week to assure proper infection control practices are being followed including hand hygiene. The results of the audits will be shared with the facility QAPI Committee and based on the results, the audits will continue daily or decrease in numbers and be discontinued once 100% compliance is demonstrated. Corrections will be monitored by: DON and Infection Preventionist	

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21375	Continued From page 15	21375		

R5's incontinence product. At 10:52 a.m. the director of nursing (DON) entered R5's room. The DON instructed NA-C to remove her gloves, clean her hands, and to put clean gloves on. NA-C walked to R5's bathroom, washed her hands, and returned to R5 with additional pairs of gloves. NA-C stated, "I should have done this in the first place." NA-C finished fastening R5's incontinence product, and R5 was rolled side-to-side and her pants were raised. The DON instructed NA-C to remove her gloves and again wash her hands.

On 11/4/20, at 11:07 a.m. an interview was conducted with registered nurse (RN)-B. RN-B stated hand hygiene needed to be completed after performing incontinence cares. RN-B stated there was a risk for contamination if staff failed to perform hand hygiene.

On 11/4/20, at 11:22 a.m. an interview was conducted with NA-C. NA-C confirmed she needed to perform hand hygiene and put on new gloves after she performed incontinence cares on R5. NA-C stated she was "nervous."

On 11/4/20, at 12:45 p.m. an interview was conducted with the DON. The DON stated staff were expected to wash their hands and change their gloves when moving from a dirty area to a clean area during resident care. The DON stated it was an infection control risk.

The facility policy Hand Hygiene dated 6/17, directed hand hygiene needed to be completed, "After contact with a resident's mucous membranes and body fluids or excretions."

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could

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21375	Continued From page 16 educate all appropriate staff on indications when hand hygiene needs to be performed. The DON, or designee, could educate all appropriate staff on the policies and procedures. The DON, or designee, could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		