

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 Therefore, the NATCEP prohibition is rescinded.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



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: 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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>

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

DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY IPLETED
		245283	B. WING				C 04/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	04/2020
	<b>TERVIEW PINES LLC</b>			12	201 8TH STREET SOUTH		
				V	IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	000			
	was conducted 11/2 facility by the Minne determine compliar	sed Infection Control survey 2/20, through 11/4/20, at your esota Department of Health to nce with Emergency lations §483.73(b)(6). The ompliance					
		nrolled in ePOC, your uired at the bottom of the first 567 form.					
F 000			F 0	000			
	On 11/2/20, throug survey and a COVI Control survey were the Minnesota Dep if your facility was in requirements of 42 Requirements for L	h 11/4/20, an abbreviated D-19 Focused Infection e conducted at your facility by artment of Health to determine					
	The following comp H5283030C	laint was substantiated:					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
LABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically 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.

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION		). 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		G		MPLETED
			_			С
		245283	B. WING		11	/04/2020
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	ERVIEW PINES LLC			1201 8TH STREET SOUTH VIRGINIA, MN 55792		
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		acceptable electronic POC, an				
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	regulations has bee	ntial compliance with the en attained in accordance with				
E 580	your verification.	Injury/Decline/Room, etc.)	F 58	0		12/4/20
SS=D			1 00			12/4/20
	§483.10(g)(14) Not	ification of Changes.				
		mediately inform the resident;				
		ident's physician; and notify, or her authority, the resident				
	representative(s) w					
	(A) An accident inv	olving the resident which				
		has the potential for requiring				
	physician interventi	on; ange in the resident's physical,				
		ocial status (that is, a				
	deterioration in hea	lth, mental, or psychosocial				
		threatening conditions or				
	clinical complication	ns); treatment significantly (that is,				
	a need to discontinu	ue an existing form of				
		lverse consequences, or to				
		orm of treatment); or ansfer or discharge the				
	· · ·	acility as specified in				
	§483.15(c)(1)(ii).					
		otification under paragraph (g)				
		n, the facility must ensure that ation specified in §483.15(c)(2)				
		wided upon request to the				
	physician.					
	resident and the res	t also promptly notify the sident representative, if any,				
	when there is- (A) A change in roo	m or roommate assignment				
						1

(EACH DEFICIENCY REGULATORY OR L Continued From pa B) A change in res State law or regular e)(10) of this section iv) The facility must update the address obone number of the epresentative(s).	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 2 ident rights under Federal or tions as specified in paragraph on. st record and periodically a (mailing and email) and	. ,	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	COMF C 11/0	E SURVEY PLETED 04/2020
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hat is a composite (483.5) must disclet ts physical configu- ocations that composite oom changes betw- under §483.15(c)(9) This REQUIREMED Dy: Based on interview facility failed to noti weight gains as orce eviewed for notification Findings include: R3's Admission Re R3's diagnoses inc CHF) and chronic	NT is not met as evidenced v and document review, the fy the physician of a resident's lered for 1 of 3 residents (R3) ation of change. cord dated 11/4/20, indicated luded congestive heart failure kidney disease.		identified. Staff identified as having a pattern recording a weight for Resident #3 counseled and re-educated on the importance of obtaining and record daily weights if ordered and docun any resident refusals.	vas of not were ding nenting	
dated 8/28/20, iden R3's MDS further id water pill) medicat R3's care plan lack	tified R13 had intact cognition. dentified he received diuretic ion on seven days. ed indication daily weights		The Policy and Procedure for Cha Resident Condition which includes notification was reviewed and rem current. All residents were reviewed to ass	nge in MD ains sure MD	
	viewed for notific ndings include: 3's Admission Re 3's diagnoses inc CHF) and chronic 3's significant cha ated 8/28/20, iden 3's MDS further ic vater pill) medicat 3's care plan lack ere to be perform	viewed for notification of change. ndings include: 3's Admission Record dated 11/4/20, indicated 3's diagnoses included congestive heart failure CHF) and chronic kidney disease. 3's significant change Minimum Data Set (MDS) ated 8/28/20, identified R13 had intact cognition. 3's MDS further identified he received diuretic vater pill) medication on seven days. 3's care plan lacked indication daily weights ere to be performed.	viewed for notification of change. ndings include: 3's Admission Record dated 11/4/20, indicated 3's diagnoses included congestive heart failure CHF) and chronic kidney disease. 3's significant change Minimum Data Set (MDS) ated 8/28/20, identified R13 had intact cognition. 3's MDS further identified he received diuretic vater pill) medication on seven days. 3's care plan lacked indication daily weights ere to be performed.	<ul> <li>viewed for notification of change.</li> <li>ndings include:</li> <li>3's Admission Record dated 11/4/20, indicated</li> <li>3's Admission Record dated 11/4/20, indicated</li> <li>3's diagnoses included congestive heart failure</li> <li>CHF) and chronic kidney disease.</li> <li>3's significant change Minimum Data Set (MDS)</li> <li>ated 8/28/20, identified R13 had intact cognition.</li> <li>3's MDS further identified he received diuretic vater pill) medication on seven days.</li> <li>3's care plan lacked indication daily weights ere to be performed.</li> <li>gain as soon as the discrepancy widentified R13 had intact cognition.</li> <li>3's care plan lacked indication daily weights ere to be performed.</li> <li>gain as soon as the discrepancy widentified R13 had intact cognition.</li> <li>All residents were reviewed to assen otification with any condition changed occurred timely. Condition changed occurred timely.</li> </ul>	<ul> <li>viewed for notification of change.</li> <li>ndings include:</li> <li>a's Admission Record dated 11/4/20, indicated</li> <li>a's diagnoses included congestive heart failure</li> <li>CHF) and chronic kidney disease.</li> <li>a's significant change Minimum Data Set (MDS)</li> <li>ated 8/28/20, identified R13 had intact cognition.</li> <li>a's MDS further identified he received diuretic vater pill) medication on seven days.</li> <li>a's care plan lacked indication daily weights ere to be performed.</li> <li>gain as soon as the discrepancy was identified.</li> <li>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.</li> <li>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.</li> <li>All residents were reviewed to assure MD notification with any condition change occurred timely. Condition change will be</li> </ul>

Facility ID: 00582

If continuation sheet Page 3 of 18

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/07/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245283	B. WING				C 04/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE WAT	TERVIEW PINES LLC				201 8TH STREET SOUTH IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	notify the heart cent two pounds in a day The order was disc of R3's MAR's from following: -R3's weight was no pounds on 9/4/20, t was documented R taken on 9/5/20, an on 9/6/20. -R3's weight was no pounds on 9/21/20, -R3's weight was no pounds on 10/7/20, -R3's weight was no pounds on 10/7/20, -R3's weight was no pounds on 10/27/20 It was documented R3 ref on 10/28/20, and no on 10/28/20, and no on 10/29/20, and 10 Review of R3's med the heart center phy weight increases or On 11/3/20, at 3:16 conducted with R3. staff didn't forgot to didn't refuse to have "everything to do wi On 11/3/20, at 3:18 conducted with nurs stated R3 was to have	was to take daily weights, and ter if R3's weight increased y, or five pounds in a week. ontinued on 11/4/20. Review 9/1/20, to 11/4/20 revealed beted to increase from 181.4 o 185.6 pounds on 9/7/20. It 3 refused to have his weight d no weight was documented beted to increase from 180.6 to 183.8 pounds on 9/22/20. beted to increase from 179.8 to 184.4 pounds on 10/8/20. beted to increase from 177.6 0, to 181 pounds on 10/31/20. Used to have his weight taken be weights were documented 0/30/20. dical record lacked indication ysician was notified of R3's in the above dates. p.m. an interview was R3 stated he believed facility take his weight. R3 stated he e his weight taken as ith my health is important." p.m. an interview was sing assistant (NA)-B. NA-B ave his weight taken daily.	F 5	580	morning stand-up. All nursing staff will be re-educated Change in Resident Condition Polic the need to notify MD timely, docun any resident treatment refusals and their supervisor. Date of Compliance: 12/4/2020 Recurrence will be prevented by: All residents with any condition cha will be reviewed weekly x 4 weekly monthly x 2 months to assure MD notification occurred, documentatio present, refusals documented and supervisor notified. The results of t audits will be shared with the facility Committee for input on the need to increase, decrease or discontinue t audits. Corrections will be monitored by: DON/Unit Managers	cy and nent I notify nge then n is these y QAPI	
	conducted with nurs stated R3 was to ha	sing assistant (NA)-B. NA-B ave his weight taken daily. s were documented in the					

		AND HUMAN SERVICES				FORM	12/07/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE COM	E SURVEY PLETED
		245283	B. WING				C 04/2020
NAME OF I	PROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC				201 8TH STREET SOUTH /IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	On 11/4/20, at 11:09 conducted with lice LPN-C stated R3 w daily, however, som stated nursing com the NAs to the last resident's record. On 11/4/20, at 11:19 conducted with regi confirmed R3 was of taken daily. RN-B re and confirmed docu missing. RN-B stat where a weight was subsequently not co RN-B stated she wa not taken, however be "repeat offender weights were not do was not known to re RN-B confirmed R3 of a two pound weig stated, "If it's not do regarding physician R3's physician shou weights were not ta increased. On 11/4/20, at 12:4 conducted with the The DON stated tw "offenders" regardin stated one staff-per The DON stated if a res benefits document	<ul> <li>9 a.m. an interview was nsed practical nurse (LPN)-C.</li> <li>as to have his weight taken netimes he refused. LPN-C pared the weight provided by documented weight in a</li> <li>9 a.m. an interview was istered nurse (RN)-B. RN-B ordered to have his weight eviewed R3's medical record umentation of weights were ted there was likely instances</li> </ul>	F 5	580			

Facility ID: 00582

If continuation sheet Page 5 of 18

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		CONSTRUCTION		E SURVEY IPLETED
		IDENTIFICATION NOMBER.	A. BUILD	ING			C
		245283	B. WING				04/2020
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
THE WAT	FERVIEW PINES LLC				01 8TH STREET SOUTH RGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 580	• • • • • • • • • • • • • • • • • • •	esident had a weight gain as	F 5	80			
	dated 6/19, directed resident/representa	hange in Resident Condition d, "The facility shall notify the tive and physician/healthcare s in the resident's condition	F 6	84			12/4/20
	applies to all treatm facility residents. Ba assessment of a re that residents recei accordance with pro practice, the compr care plan, and the r	fundamental principle that lent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of ehensive person-centered					
	Based on interview facility failed to con- and monitor blood p (R1) who was hypo	and document review, the duct follow-up assessments pressures for 1 of 3 residents tensive (had low blood on, the facility failed to obtain of 3 residents (R3).			F Tag: F684 Quality of Care Immediate Corrective Action: Immediate education for all license nurses began on 11/3/2020 regard need for follow up assessments w resident was hypotensive as was displayed by Resident #1.	ling the hen a	
		cord dated 11/4/20, indicated			Resident #3 MD was notified of his gain as soon as the discrepancy we identified. Staff identified as having a pattern recording a weight for Resident #3	vas of not 8 were	
	R1's diagnoses incl fibrillation (irregular hypertension.	uded heart failure, atrial heart rhythm), and			counseled and re-educated on the importance of obtaining and recor- daily weights if ordered and docun any resident refusals.	ding	

Facility ID: 00582

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	-	AND HUMAN SERVICES					APPROVEI 0938-039		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			X3) DATE COMF	SURVEY		
		245283	B. WING			C 11/0	; 4/2020		
NAME OF F	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE				
THE WAT	<b>TERVIEW PINES LLC</b>				201 8TH STREET SOUTH /IRGINIA, MN 55792				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIOI DATE		
F 684	Continued From pa	nge 6	F 6	84					
	R1's admission Mir 8/18/20, identified F R1's Medication Ad dated 9/1/20, to 9/3 intake, every shift, a R1's ADL (activities Rehabilitation Pote (CAA) dated 8/20/2 with therapy to imp functional abilities.	himum Data Set (MDS) dated R1 had intact cognition. Iministration Record (MAR) 80/20, directed encourage fluid as blood pressure was low. 6 of daily living) Functional / ntial Care Area Assessment 20, indicated R1 was working rove her strength and overall The CAA further indicated s to be discharged home,		_	Corrective Action as it applies to othe The Policy and Procedure for Change Resident Condition was reviewed and remains current. The Policy and Procedure for Resident Weight Evalu was reviewed and remains current. All residents were reviewed to assure notification with any condition change occurred timely, as well as completio any follow-up assessments indicated documentation of any treatment refus is present and notification of supervisi condition changes or treatment refus	e in d uation e MD e on of l, sals sor of			
	however, safety an barriers. R1's care plan date an alteration in hen	d cognition were potential ed 8/26/20, indicated R1 had natological (blood) status. The to give medications, as or for side			Condition change will be a focus topic reviewed and discussed at morning stand-up. All nursing staff will be re-educated o Change in Resident Condition Policy the Resident Weight Evaluation Polic and the need to notify MD timely, initi any follow-up assessments, documer any resident treatment refusals and re	ic on the v and cy iate ont			
	<ul> <li>Review of R1's blood pressures revealed the following:</li> <li>R1's blood pressure was documented as 76/46 on 9/9/20, at 10:27 p.m.</li> <li>R1's blood pressure was documented as 88/54 on 9/9/20, at 11:14 p.m.</li> <li>R1's blood pressure was documented as 92/72 on 9/10/20, at 3:01 a.m.</li> <li>No blood pressures were documented from 9/11/20, to 9/13/20.</li> <li>R1's blood pressure was documented as 70/40 on 9/14/20, at 12:55 p.m.</li> </ul>				their supervisor for condition changes treatment refusals. Date of Compliance: 12/4/2020 Recurrence will be prevented by: All residents with any condition chang will be reviewed weekly x 4 weeks the monthly x 2 months to assure MD notification occurred, follow-up assessments are initiated, document is present, refusals documented and supervisor notified. The results of the audits will be shared with the facility of Committee for input on the need to increase, decrease or discontinue the audits	ge en ntation ese QAPI			
	indicated R1 had a physician for a "ras	telehealth visit with her h under her left breast." The er indicated there were, "No			audits Corrections will be monitored by: DON/Unit Managers				

Facility ID: 00582

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		E CONSTRUCTION	(X3) DATI	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			PLETED C
		245283	B. WING_				04/2020
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC				201 8TH STREET SOUTH /IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	other concerns at th	nis time."	F 68	84			
	Care dated 9/11/20 consultation was co The document indic cognition was "rathe further indicated R1 her blood pressures 92/72. Nursing was	ssentia Health - Virginia Elder , indicated a telemedicine ompleted with R1's physician. cated nursing reported R1's er poor." The document "was not drinking a lot" and s were 88/54, 76/46, and s "going to push fluids a bit to eported feeling "fine."					
	indicated R1 was "v to stand independe R1 was unable to k questions. R1's vita pressure was "low.' and an order was o	ted 9/14/20, at 12:56 p.m. very lethargic" and was unable ntly "as she had been doing." eep her eyes open to answer al signs indicated her blood ' R1's physician was notified btained to send R1 to the nent. R1's daughter was R1's window.					
	indicated R1's repre R1 was septic (seven was "bad." The pro R1's representative visited with family o	ted 9/14/20, at 1:00 p.m. esentative updated the facility ere infection) and R1's urine ogress note further indicated stated R1 was talkative and n 9/12/20, however, only no" questions on 9/13/20.					
		dical record lacked indication ents were conducted from					
	conducted with lice LPN-A stated some other times she was	p.m. an interview was nsed practical nurse (LPN)-A. times R1 was "clear" and sn't. LPN-A stated she did not blood pressure or change of					

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		DENTITION TON NONDER.	A. BUILDI	NG	i		C
		245283	B. WING			11/0	04/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WAT	ERVIEW PINES LLC				1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 684	Continued From par condition. On 11/3/20, at 12:21 conducted with fam R1 tripped on a car (vertebrae) fracture facility. F-A stated I for bedrest and they spoke to R1 on 9/12 F-A stated sometim 9/14/20, "Something stated she received told R1 was going to department. F-A st and looked through was unable to hang was "weak" and "loo was moaning. F-A R1's window for thre were in R1's room. registered nurse (R R1's blood pressure three people then c quickly." F-A stated the hospital. F-A st physician told her R survive, and R1 loo stated she was told 50/47. F-A stated F R1's urine looked lii R1 had a lack of ox severely dehydrated	ge 8 6 p.m. an interview was ily member (F)-A. F-A stated pet and suffered a T11 prior to admission to the R1 was admitted to the facility rapy. F-A stated her sister 2/20, and R1 was "doing fine." be between 9/12/20, and g happened to her [R1]." F-A a call on 9/14/20, and was o be sent to the emergency ated she went to the facility R1's window. F-A stated R1 onto a phone because she oked gray." F-A stated R1 stated she stood outside of ee to five minutes and no staff F-A stated she called N)-A and she was informed e was "really low." F-A stated ame to R1's room "very d she then left to meet R1 at ated once at the hospital, the R1 was not expected to ked like she was dying. F-A R1's blood pressure was R1 had a catheter placed and ke "creamed corn." F-A stated ygen to her brain and was d. F-A stated R1 had since om the hospital and was	F 6		DEFICIENCY)	RATE	DATE
	conducted with LPN a lot of cares and w	p.m. an interview was N-B. LPN-B stated R1 refused vas a "confused lady." LPN-B ot" and did not recall a change					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 12/07/2020 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION G	(X3) DAT CON	E SURVEY IPLETED
		245283	B. WING	;			C 04/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					1201 8TH STREET SOUTH		
	<b>TERVIEW PINES LLC</b>				VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	report a low blood p manager and encou LPN-B stated she w had a low blood pre- On 11/3/20, at 3:27 conducted with regis stated R1 was adm short-term rehabilita "very independent I her. RN-A stated co on R1, and it was d RN-A stated she wa "something was wro was lethargic, howe "fine." RN-A stated window at this time be sent out becauss previously was. RN obtained a bed hold R1's was speaking was transferred to t daughter later calle urinary tract infection informed her R1 wa however, R1 was u 9/13/20. RN-A stated worked on 9/13/20, seem like her "old s RN-A stated she wa nurse was. RN-A s remembered speak 9/11/20, and being blood pressure read frequency of blood	LPN-B stated she would pressure reading to her unit urage a resident to drink fluids. yould reassess a resident, who assure, every 15 minutes. p.m., an interview was stered nurse (RN)-A. RN-A itted to the facility for ation. RN-A stated R1 was a ady" and told staff not to "bug" ognitive testing was conducted etermined R1 had dementia. as informed on 9/14/20, ong" with R1. RN-A stated R1 ever, R1 verbalized she was R1's daughter was at R1's . RN-A stated R1 needed to e she was not as alert as she I-A stated she left R1's room, d form, and returned and found "gibberish." RN-A stated R1 he hospital, and R1's d and stated R1 had a "bad" on. RN-A stated R1's family as "really talkative" on 9/12/20, nable to hold a telephone on ed she spoke with staff who and nurse told her R1 didn't self" and R1 was "sleepier." as unable to recall who the tated she "vaguely" ting to R1's physician on told to push fluids due to low dings. RN-A stated the pressure monitoring was	F	684			
	9/11/20, and being blood pressure read frequency of blood dependent upon rea resident's blood pre	told to push fluids due to low dings. RN-A stated the					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/07/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```			(X3) DATE COM	E SURVEY IPLETED
		245283	B. WING				C 04/2020
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC				I201 8TH STREET SOUTH /IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	RN-A stated staff "p R1's blood pressure On 11/4/20, at 12:4 conducted with the The DON stated sta follow-up assessme were identified. The consultant had revid determined staff ne pressures, and upd DON stated R1 was it was reported R1 v DON stated "most" change of condition The DON stated sta RN or leave a note a resident had a ch stated staff education The facility policy C dated 6/19, directed physician/healthcar make detailed obse and pertinent inform Weights R3's Admission Ree R3's diagnoses incl (CHF) and chronic R3's significant chai identified R3 had in further identified he (water pill) on seven	brobably" should had followed e more closely. 5 p.m. an interview was director of nursing (DON). aff were expected to conduct ents when abnormal values e DON stated a corporate ewed R1's medical record and eded to recheck R1's blood ate the medical provider. The s "good" on 9/12/20, however, was "sleepy" on 9/13/20. The nurses' were educated on and what sepsis looked like. aff should not wait to talk to the for the clinical manager when ange of condition. The DON on was started on 11/3/20. hange in Resident Condition d, "Prior to notifying the e provider, the nurse will ervations and gather relevant nation for the provider."	F	584			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
			A. BUILD	ING	3		C
		245283	B. WING			11	/04/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WAT	TERVIEW PINES LLC				1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 684	Continued From pa	ge 11	F 6	684	L L		
	directed R3 was to due to CHF. The o	ministration record (MAR) have his weight taken daily rder was discontinued on R3's MAR's from 9/1/20, to Illowing:					
	9/10/20, 9/11/20, 9/ 9/19/20/ 9/23/20, 9/ 10/14/20, 10/16/20, 10/22/20, 10/25/20, and 11/3/20. -Weights were docu	ocumented on 9/3/20, 9/6/20, 12/20, 9/13/20, 9/18/20, 26/20, 9/29/20,10/6/20, 10/17/20, 10/20/20, 10/21/20, 10/29/20,10/30/20, 11/1/20, umented as refused on 9/5/20, 15/20 and 10/28/20.					
	conducted with R3. staff didn't forgot to didn't refuse to have "everything to do wi On 11/3/20, at 3:18 conducted with NA-	p.m. an interview was R3 stated he believed facility take his weight. R3 stated he e his weight taken as th my health is important." p.m. an interview was B. NA-B stated R3 was to					
		en daily. NA-B stated weights n the electronic medical					
	conducted with LPN	9 a.m. an interview was I-C. LPN-C stated R3 was to en daily, however, sometimes					
	conducted with RN- ordered to have his reviewed R3's medi documentation of w	9 a.m. an interview was •B. RN-B confirmed R3 was weight taken daily. RN-B ical record and confirmed reights were missing. RN-B ely instances where a weight					

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		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C	
		245283	B. WING	 		04/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC			I201 8TH STREET SOUTH /IRGINIA, MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684 F 880 SS=D	was not obtained an communicated to the unsure why weights verbalized there appoffenders" on the da documented. RN-E refuse having his w On 11/4/20, at 12:45 conducted with the staff were identified regarding R3's weights staff-person was all stated staff were ex- ordered, or docume if a resident refused document needed to The facility policy R dated 9/12, directed Monarch Healthcard facilities to obtain al upon admission or shall be done for ea- often according to to consensus between Infection Prevention CFR(s): 483.80(a)(to \$483.80 Infection C The facility must es- infection prevention designed to provide comfortable environ development and tr diseases and infection	nd subsequently not ne next shift. RN-B she was s were not taken, however, peared to be "repeat ates in which weights were not 3 stated R3 was not known to reight taken. 5 p.m., an interview was DON. The DON stated two a s being "offenders" ghts. The DON stated one ready reeducated. The DON spected to obtain weights, as ent refusals. The DON stated d, a risk versus benefits to be completed. esident Weight Evaluation d, "It is the policy of all e Management Rehabilitation n accurate weight of residents readmission. Further, weights ach resident monthly or more he physician's order, or a in the interdisciplinary team." n & Control 1)(2)(4)(e)(f) control tablish and maintain an a and control program a safe, sanitary and ment and to help prevent the ransmission of communicable	F 6			12/4/20

Facility ID: 00582

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		245283	B. WING				C 04/2020	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
THE WAT	ERVIEW PINES LLC			1201 8TH STREET SOUTH VIRGINIA, MN 55792				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 880	and control program a minimum, the folk §483.80(a)(1) A sys reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based conducted accordin accepted national s §483.80(a)(2) Writte procedures for the p but are not limited t (i) A system of surve possible communic infections before the persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tra- to be followed to pro- (iv)When and how i resident; including to (A) The type and du depending upon the involved, and (B) A requirement the least restrictive pos- circumstances. (v) The circumstance must prohibit emplo-	tablish an infection prevention n (IPCP) that must include, at owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual I upon the facility assessment og to §483.70(e) and following tandards; en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other ty; iom possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a	F 8	80				

		AND HUMAN SERVICES & MEDICAID SERVICES			FORI	D: 12/07/2020 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245283	B. WING		11	/04/2020
NAME OF F	PROVIDER OR SUPPLIER		1	S	IREET ADDRESS, CITY, STATE, ZIP CODE	
THE WAT	ERVIEW PINES LLC				201 8TH STREET SOUTH IRGINIA, MN 55792	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	by staff involved in o §483.80(a)(4) A sys- identified under the corrective actions ta §483.80(e) Linens. Personnel must har transport linens so a infection. §483.80(f) Annual r The facility will cond IPCP and update th This REQUIREMEN by: Based on observat review, the facility fa was completed duri prevent cross conta (R5) reviewed for b- incontinence. Findings include: R5's Diagnoses Re R5's diagnoses incl behavioral disturbat R5's quarterly Minin 10/8/20, identified F cognition. R5's MD totally dependent up always incontinent of R5's care plan date	t the disease; and he procedures to be followed direct resident contact. Atem for recording incidents facility's IPCP and the aken by the facility. Adde, store, process, and as to prevent the spread of eview. duct an annual review of its heir program, as necessary. NT is not met as evidenced ion, interview, and document ailed to ensure hand hygiene ng incontinence cares to amination for 1 of 3 residents owel and bladder	F	380	F Tag: F880 DPOC Immediate Corrective Action: NA-C was counseled and re-educated with return demonstration competency or 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 Roo 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	ot S

Facility ID: 00582

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
				C
	245283	B. WING		11/04/2020
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ERVIEW PINES LLC			1201 8TH STREET SOUTH VIRGINIA, MN 55792	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE COMPLETIO
	-	F 880		
care after each inco On 11/4/20, at 10:3 (NA)-C entered R5' put on a pair of glow from a wheelchair to ceiling lift. NA-C low unfastened R5's so NA-C grabbed wet area, and disposed can. NA-C stated R R5 to reach for a si back and rolled R5 exposed portion of product to wipe stoc then partially rolled product, and pulled soiled incontinence bed. NA-C obtaine cleaned R5's buttoo on the soiled incont R5's bed. NA-C dis incontinence produc changing gloves or NA-C obtained a cle partially placed it ur to roll on her back a NA-C touched R5's shoulder, and briefl soiled gloved hand. and assisted R5 rol on her back with he pulled the clean inc	ontinent episode. 9 a.m. nursing assistant s room, provided privacy, and ves. NA-C transferred R5 o a bed, using a mechanical vered R5's pants and iled incontinence product. wipes, cleaned R5's groin of the wet wipes in a garbage .5 was "wet," and encouraged de rail. NA-C pushed on R5's to her left side. NA-C used an R5's soiled incontinence ol off of R5's buttocks. NA-C R5's soiled incontinence it out from under R5. The product remained on R5's d additional wet wipes, cks, and placed each wet wipe inence product which was on sposed of the soiled ct in a garbage. Without performing hand hygiene, ean incontinence product and nder R5. NA-C instructed R5 and R5 let go of the bed rail. blue sweater near R5's right y held R5's right hand with her NA-C walked to R5's left side I to her right side by pushing er soiled gloved hands. NA-C ontinence product from under		MDH will be utilized for the re-edu The DON, Infection Preventionist Clinical Education Coordinator wi conduct return demonstration competencies on proper hand hy with all staff and maintain a log w results. Date of Compliance: 12/4/2020 Recurrence will be prevented by: The DON, Infection Preventionist other leadership staff will conduct on all shifts, every day for one we assure proper infection control pr are being followed including hand hygiene. The results of the audits shared with the facility QAPI Corr and based on the results, the audits	and and giene ith and t audits sek to actices s will be mittee lits will
	OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER ERVIEW PINES LLC SUMMARY STA (EACH DEFICIENCY REGULATORY OR LI Continued From pa care plan directed s care after each inco On 11/4/20, at 10:3 (NA)-C entered R5' put on a pair of glov from a wheelchair t ceiling lift. NA-C lov unfastened R5's so NA-C grabbed wet area, and disposed can. NA-C stated R R5 to reach for a si back and rolled R5 exposed portion of product to wipe stor then partially rolled product, and pulled soiled incontinence bed. NA-C obtaine cleaned R5's buttoo on the soiled incont R5's bed. NA-C dis incontinence produc changing gloves or NA-C obtained a cle partially placed it ur to roll on her back a NA-C touched R5's shoulder, and briefl soiled gloved hand. and assisted R5 rol on her back with he pulled the clean inc	OF DEFICIENCIES F CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         245283         PROVIDER OR SUPPLIER <b>TERVIEW PINES LLC</b> SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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 soil	F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         245283       B. WING	OF DEFICIENCIES F CORRECTION       (X1) PROVIDERSUPPLER/CLA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING         245283       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH VIRGINIA, MN 55792         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MEST PROFEDENCIES (EACH DEFICIENCY MEST PROFEDENCIES) (EACH DEFICIENCY)         Continued From page 15 care plan directed staff to provide incontinence care after each incontinence product. 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 can. NA-C lowered R5's pants and unfastened R5's solied incontinence product, and pulled in cut from under R5. Side incontinence product to wipe stool off of R5's buttocks. NA-C then partially rolled R5's solied incontinence product to wipe stool off of R5's buttocks. NA-C then partially rolled R5's solied incontinence product to wipe stool off of R5's buttocks. NA-C then partially rolled R5's solied incontinence product to wipe stool off of R5's buttocks. NA-C then partially rolled R5's solied incontinence product to wipe stool off R5's solied and continence product to wipe stool off R5's solied and continence product to AN-C disposed of the solied incontinence product mainden R5. The solied 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 lute solied incontinence product rand partially placed it under R5. ThA-C i

If continuation sheet Page 16 of 18

		AND HUMAN SERVICES				FORM	APPROVED
	CS FOR MEDICARE	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	тір	PLE CONSTRUCTION		0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			G	COMPLETED	
			_				С
		245283	B. WING			11/04/2020	
NAME OF F	PROVIDER OR SUPPLIER	-		ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE WAT	<b>TERVIEW PINES LLC</b>				1201 8TH STREET SOUTH		
					VIRGINIA, MN 55792		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL	ID PREFIX	~	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	^	CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
		40		~ ~			
F 880	• · · · · · · · · · · · · · · · · · · ·	•	F 8	80	)		
	gloves. R5 grabbed additional wet wipes and wiped R5's inner thighs. NA-C started to faste						
		product. At 10:52 a.m. the					
	director of nursing (	(DON) entered R5's room.					
		d NA-C to remove her gloves,					
		nd to put clean gloves on. 's bathroom, washed her					
		d to R5 with additional pairs of					
	gloves. NA-C state	d, "I should have done this in					
		-C finished fastening R5's					
		ct, and R5 was rolled r pants were raised. The DON					
		remove her gloves and again					
	wash her hands.	6 6					
	On 11/1/20 at 11:0						
		7 a.m. an interview was istered nurse (RN)-B. RN-B					
		e needed to be completed					
		continence cares. RN-B stated					
		contamination if staff failed to					
	perform hand hygie	ene.					
	On 11/4/20, at 11:22	2 a.m. an interview was					
		-C. NA-C confirmed she					
		hand hygiene and put on new					
	R5. NA-C stated sl	rformed incontinence cares on he was "nervous"					
		5 p.m. an interview was					
		DON. The DON stated staff					
		ash their hands and change noving from a dirty area to a					
		esident care. The DON stated					
	it was an infection of						
	The facility policy U	and Hygiona datad 6/17					
		and Hygiene dated 6/17, ene needed to be completed,					
		a resident's mucous					
	membranes and bo	ody fluids or excretions."					

If continuation sheet Page 17 of 18

		AND HUMAN SERVICES				FORM	APPROVED
							0938-0391
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	COM	E SURVEY IPLETED
						С	
		245283	B. WING	_		11/	04/2020
NAME O	F PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE W	ATERVIEW PINES LLC				1201 8TH STREET SOUTH VIRGINIA, MN 55792		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PRÉFIX TAG	( EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
		,			DEFICIENCY)		

Facility ID: 00582

If continuation sheet Page 18 of 18



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>. 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.

# The Waterview Pines Llc November 24, 2020 Page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

Minnesc	ota Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00582	B. WING		0 11/0	) 4/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			STREET SO			
THE WA	TERVIEW PINES LLC	VIRGINIA	, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	survey was conduct with State Licensurvey NOT in compliance Please indicate in y correction that you and identify the date	FS: n 11/4/20, an abbreviated ted to determine compliance e. Your facility was found to be with the MN State Licensure. our electronic plan of have reviewed these orders, e when they will be completed.				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 12/04/20

Electronically Signed

STATE FORM

If continuation sheet 1 of 17

		Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00582	B. WING		11/04/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		H STREET SOU A, MN 55792	UTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	The following com	plaint was found to be : H5283030C				
	signature is not rec page of state form. On 11/2/20, throug Department's staff the following correc Please indicate in correction that you	led in ePOC and therefore a quired at the bottom of the first h 11/4/20, surveyors of this , visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, te when they will be completed				
2 265	MN Rule 4658.008 Resident Health St	5 Notification of Chg in atus	2 265			12/4/20
	policies to guide st physicians, physici practitioners, and i legal representative member of a reside accident, or death. nursing services, a attending physician development of the	ust develop and implement aff decisions to consult an assistants, and nurse f known, notify the resident's e or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an must be involved in the ese policies. The policies must address at least the ation times for:				
	results in injury and physician intervent B. a significan	t change in the resident's				
	example, a deterio	or psychosocial status, for ration in health, mental, or s in either life-threatening al complications;				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY	
			A. BUILDING	:	С	
		00582	B. WING		11/04/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		I STREET SC A, MN 55792			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET DATE	
2 265	Continued From pa	age 2	2 265			
	example, a need to	Iter treatment significantly, for o discontinue an existing form o adverse consequences, or to of treatment;				
	D. a decision resident from the n	to transfer or discharge the ursing home; or				
	E. expected ar	nd unexpected resident deaths.				
	This MN Requirem by:	ent is not met as evidenced				
	facility failed to noti	and document review, the fy the physician of a resident's dered for 1 of 3 residents (R3) ation of change.		F Tag: F580 Notification Immediate Corrective Action: Resident #3 MD was notified of his weig gain as soon as the discrepancy was identified.	ght	
	Findings include:			Staff identified as having a pattern of no recording a weight for Resident #3 were		
		cord dated 11/4/20, indicated luded congestive heart failure kidney disease.		counseled and re-educated on the importance of obtaining and recording daily weights if ordered and documentin any resident refusals.		
	dated 8/28/20, ider	ange Minimum Data Set (MDS) ntified R13 had intact cognition. dentified he received diuretic ion on seven days.		Corrective Action as it applies to others The Policy and Procedure for Change i Resident Condition which includes MD notification was reviewed and remains current.		
	were to be perform			All residents were reviewed to assure N notification with any condition change occurred timely. Condition change will	be	
	directed the facility notify the heart cen two pounds in a da	Iministration record (MAR) was to take daily weights, and iter if R3's weight increased y, or five pounds in a week.		a focus topic reviewed and discussed a morning stand-up. All nursing staff will be re-educated on the Change in Resident Condition Policy are the paged to patify MD timely, desugart	he Id	
		continued on 11/4/20. Review n 9/1/20, to 11/4/20 revealed		the need to notify MD timely, document any resident treatment refusals and not their supervisor.		

If continuation sheet 3 of 17

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	ETED
		00582	B. WING		4/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		I STREET SO A, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	ge 3	2 265			
	-R3's weight was no pounds on 9/4/20, t was documented R taken on 9/5/20, an on 9/6/20. -R3's weight was no pounds on 9/21/20, -R3's weight was no pounds on 10/7/20, -R3's weight was no pounds on 10/27/20 It was documented R3 ref on 10/28/20, and no on 10/29/20, and 10 Review of R3's meet the heart center phy weight increases or On 11/3/20, at 3:16 conducted with R3. staff didn't forgot to didn't refuse to have "everything to do wi On 11/3/20, at 3:18 conducted with nurs stated R3 was to ha NA-B stated weight electronic medical r On 11/4/20, at 11:09 conducted with lice LPN-C stated R3 w daily, however, som stated nursing com	bted to increase from 181.4 o 185.6 pounds on 9/7/20. It 3 refused to have his weight d no weight was documented bted to increase from 180.6 to 183.8 pounds on 9/22/20. bted to increase from 179.8 to 184.4 pounds on 10/8/20. bted to increase from 177.6 0, to 181 pounds on 10/31/20. Tused to have his weight taken b weights were documented D/30/20. dical record lacked indication ysician was notified of R3's in the above dates. p.m. an interview was R3 stated he believed facility take his weight. R3 stated he e his weight taken as th my health is important." p.m. an interview was sing assistant (NA)-B. NA-B ave his weight taken daily. s were documented in the		Date of Compliance: 12/4/2 Recurrence will be prevent All residents with any condi be reviewed weekly x 4 we monthly x 2 months to assu notification occurred, docur present, refusals document supervisor notified. The re audits will be shared with th Committee for input on the increase, decrease or disco audits. Corrections will be monitore DON/Unit Managers	ed by: tion change will ekly then ure MD mentation is ted and sults of these he facility QAPI need to pontinue the	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING:				
		00582	B. WING			C 11/04/2020	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
	<b>TERVIEW PINES LLC</b>		STREET SOL , MN 55792	JTH			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	COMPLET DATE	
2 265	Continued From pa	ige 4	2 265				
	conducted with reg confirmed R3 was taken daily. RN-B re and confirmed documissing. RN-B state where a weight was subsequently not co RN-B stated she was not taken, however be "repeat offender weights were not do was not known to re RN-B confirmed R3 of a two pound weights stated, "If it's not do regarding physician R3's physician shou	9 a.m. an interview was istered nurse (RN)-B. RN-B ordered to have his weight eviewed R3's medical record umentation of weights were ted there was likely instances is not obtained and ommunicated to the next shift. as unsure why weights were y verbalized there appeared to rs" on the dates in which ocumented. RN-B stated R3 efuse having his weight taken. 3's physician was to be notified ght increase in a day. RN-B ocumented, it is not done" in notification. RN-B stated uld had also be notified when aken, and R3 had a weight					
	conducted with the The DON stated tw "offenders" regardin stated one staff-per The DON stated sta weights, as ordered DON stated if a res benefits document DON stated staff w physician when a re there was a risk for	5 p.m. an interview was director of nursing (DON). to staff were identified as being ng R3's weights. The DON rson was already reeducated. aff were expected to obtain d, or document refusals. The ident refused, a risk versus needed to be completed. The ere expected to update the esident had a weight gain as fluid overload.					
	dated 6/19, directed resident/representation	d, "The facility shall notify the ative and physician/healthcare s in the resident's condition					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED C
		00582	B. WING	1/04/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
THE WA	TERVIEW PINES LLC		H STREET SO A, MN 55792	UTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 265	Continued From pa	ge 5	2 265		
	The Director of Nur could develop, revie procedures to ensur representatives/phy change in condition designee, could edu the policies and pro designee, could dev ensure ongoing cor	vsicians are notified of a or treatment. The DON, or ucate all appropriate staff on ocedures. The DON, or velop monitoring systems to	•		
2 830	MN Rule 4658.0520 Proper Nursing Car	) Subp. 1 Adequate and re; General	2 830		12/4/20
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.	d t		
	by: Based on interview facility failed to con and monitor blood	ent is not met as evidenced and document review, the duct follow-up assessments pressures for 1 of 3 residents tensive (had low blood		F Tag: F684 Quality of Care Immediate Corrective Action: Immediate education for all licensed nurses began on 11/3/2020 regarding th	ne

STATEMEN	o <u>ta Department of He</u> NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
AND FLAN		IDENTIFICATION NOWIDER.	A. BUILDING	:		
	<b>00582</b> B. W		B. WING		C 11/04	1/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
	TERVIEW PINES LLC	1201 8TH	I STREET SO	ОЛТН		
		VIRGINIA	, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 6	2 830			
	daily weights for 1 d	on, the facility failed to obtain of 3 residents (R3).		need for follow up assessments w resident was hypotensive as was displayed by Resident #1.		
	Findings include: Assessment/Blood	Pressure		Resident #3 MD was notified of hi gain as soon as the discrepancy wi identified.		
	R1's Admission Re	cord dated 11/4/20, indicated luded heart failure, atrial		Staff identified as having a pattern recording a weight for Resident # counseled and re-educated on the importance of obtaining and record daily weights if ordered and docur	3 were e ding	
		nimum Data Set (MDS) dated R1 had intact cognition.		any resident refusals. Corrective Action as it applies to c The Policy and Procedure for Cha Resident Condition was reviewed	ange in	
	dated 9/1/20, to 9/3	ministration Record (MAR) 0/20, directed encourage fluid as blood pressure was low.		remains current. The Policy and Procedure for Resident Weight Ev was reviewed and remains curren All residents were reviewed to ass	ıt.	
	Rehabilitation Pote (CAA) dated 8/20/2 with therapy to imp functional abilities. R1's initial plan was	of daily living) Functional / ntial Care Area Assessment 0, indicated R1 was working rove her strength and overall The CAA further indicated is to be discharged home, d cognition were potential		notification with any condition cha occurred timely, as well as comple any follow-up assessments indica documentation of any treatment re present and notification of superv condition changes or treatment re Condition change will be a focus t reviewed and discussed at mornin stand-up.	nge etion of ted, efusals is isor of fusals. opic	
	an alteration in hem			All nursing staff will be re-educate Change in Resident Condition Po the Resident Weight Evaluation P the need to notify MD timely, initia follow-up assessments, documen	licy and olicy and ite any t any	
	following: - R1's blood pressu on 9/9/20, at 10:27	ire was documented as 88/54		resident treatment refusals and no supervisor for condition changes treatment refusals. Date of Compliance: 12/4/2020 Recurrence will be prevented by: All residents with any condition ch be reviewed weekly x 4 weeks the	or ange will	

If continuation sheet 7 of 17

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	
		IDENTIFICATION NOWBER.	A. BUILDING	:		
		00582	B. WING		C 11/04	; 4/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		I STREET SC			
		VIRGINIA	, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ige 7	2 830			
	<ul> <li>Continued From page 7</li> <li>R1's blood pressure was documented as 92/72 on 9/10/20, at 3:01 a.m.</li> <li>No blood pressures were documented from 9/11/20, to 9/13/20.</li> <li>R1's blood pressure was documented as 70/40 on 9/14/20, at 12:55 p.m.</li> <li>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."</li> <li>A document titled Essentia Health - Virginia Elder</li> </ul>			monthly x 2 months to assund notification occurred, follow assessments are initiated, is present, refusals docume supervisor notified. The res audits will be shared with th Committee for input on the increase, decrease or disco audits Corrections will be monitore DON/Unit Managers	-up documentation ented and sults of these le facility QAPI need to ontinue the	
	Care dated 9/11/20 consultation was co The document indic cognition was "rathe further indicated R1 her blood pressures 92/72. Nursing was	, indicated a telemedicine ompleted with R1's physician. cated nursing reported R1's er poor." The document 1 "was not drinking a lot" and s were 88/54, 76/46, and s "going to push fluids a bit to eported feeling "fine."				
	indicated R1 was "\ to stand independe R1 was unable to k questions. R1's vita pressure was "low." and an order was o	ted 9/14/20, at 12:56 p.m. very lethargic" and was unable ntly "as she had been doing." eep her eyes open to answer al signs indicated her blood " R1's physician was notified obtained to send R1 to the nent. R1's daughter was R1's window.				
monto	indicated R1's repre R1 was septic (sev was "bad." The pro R1's representative visited with family o	ted 9/14/20, at 1:00 p.m. esentative updated the facility ere infection) and R1's urine ogress note further indicated e stated R1 was talkative and on 9/12/20, however, only no" questions on 9/13/20.				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		COM	E SURVEY PLETED
		00582	0582 B. WING		C 11/04/202	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
	TERVIEW PINES LLC		I STREET SOL A, MN 55792	JTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 8	2 830			
		dical record lacked indication ents were conducted from				
	conducted with lice LPN-A stated some other times she was	p.m. an interview was nsed practical nurse (LPN)-A. times R1 was "clear" and sn't. LPN-A stated she did not blood pressure or change of				
	conducted with fam R1 tripped on a car (vertebrae) fracture facility. F-A stated for bedrest and the spoke to R1 on 9/11 F-A stated sometim 9/14/20, "Somethin	6 p.m. an interview was ily member (F)-A. F-A stated pet and suffered a T11 prior to admission to the R1 was admitted to the facility rapy. F-A stated her sister 2/20, and R1 was "doing fine." be between 9/12/20, and g happened to her [R1]." F-A I a call on 9/14/20, and was				
	told R1 was going t department. F-A st and looked through was unable to hang was "weak" and "lo	ated she went to the emergency ated she went to the facility R1's window. F-A stated R1 onto a phone because she oked gray." F-A stated R1 stated she stood outside of				
	R1's window for thr were in R1's room. registered nurse (R R1's blood pressure	ee to five minutes and no staff F-A stated she called N)-A and she was informed e was "really low." F-A stated				
	quickly." F-A stated the hospital. F-A st physician told her F	ame to R1's room "very d she then left to meet R1 at ated once at the hospital, the R1 was not expected to ked like she was dying. F-A				
	stated she was told 50/47. F-A stated F	R1's blood pressure was R1 had a catheter placed and ke "creamed corn." F-A stated				

If continuation sheet 9 of 17

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00582	B. WING			04/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	FERVIEW PINES LLC		I STREET SOL A, MN 55792	JTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	qe 9	2 830			
	R1 had a lack of ox severely dehydrated	ygen to her brain and was d. F-A stated R1 had since om the hospital and was				
	conducted with LPN a lot of cares and w stated R1 "slept a lo in condition for R1. report a low blood p manager and encou LPN-B stated she w	p.m. an interview was N-B. LPN-B stated R1 refused vas a "confused lady." LPN-B ot" and did not recall a change LPN-B stated she would pressure reading to her unit urage a resident to drink fluids yould reassess a resident, who essure, every 15 minutes.				
	conducted with registred R1 was adm short-term rehabilitation "very independent la her. RN-A stated co on R1, and it was d RN-A stated she was "something was wrow was lethargic, howe "fine." RN-A stated window at this time be sent out because previously was. RN obtained a bed hold R1's was speaking was transferred to t daughter later calle urinary tract infection informed her R1 was however, R1 was u	p.m., an interview was stered nurse (RN)-A. RN-A itted to the facility for ation. RN-A stated R1 was a ady" and told staff not to "bug" ognitive testing was conducted etermined R1 had dementia. as informed on 9/14/20, ong" with R1. RN-A stated R1 ever, R1 verbalized she was R1's daughter was at R1's . RN-A stated R1 needed to e she was not as alert as she I-A stated she left R1's room, I form, and returned and found "gibberish." RN-A stated R1 he hospital, and R1's d and stated R1 had a "bad" on. RN-A stated R1's family as "really talkative" on 9/12/20, nable to hold a telephone on	1			
	worked on 9/13/20, seem like her "old s	ed she spoke with staff who and nurse told her R1 didn't self" and R1 was "sleepier." as unable to recall who the				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00582	B. WING			C 04/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		I STREET SOU A, MN 55792	JTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	nurse was. RN-A s remembered speak 9/11/20, and being t blood pressure read frequency of blood dependent upon rea resident's blood pre- would expect the ch RN-A stated staff "p R1's blood pressure On 11/4/20, at 12:4 conducted with the The DON stated staff follow-up assessme were identified. The consultant had revie determined staff ne pressures, and upd DON stated R1 was it was reported R1 was it aresident had a ch stated staff education The DON stated staff RN or leave a note a resident had a ch stated staff education The facility policy C dated 6/19, directed physician/healthcar make detailed obset and pertinent inform Weights R3's Admission Rea	tated she "vaguely" ing to R1's physician on told to push fluids due to low dings. RN-A stated the pressure monitoring was adings. RN-A stated if a assure was less than 100 she harge nurse to be updated. probably" should had followed e more closely. 5 p.m. an interview was director of nursing (DON). aff were expected to conduct ents when abnormal values e DON stated a corporate ewed R1's medical record and eded to recheck R1's blood ate the medical provider. The s "good" on 9/12/20, however, was "sleepy" on 9/13/20. The nurses' were educated on and what sepsis looked like. aff should not wait to talk to the for the clinical manager when ange of condition. The DON on was started on 11/3/20. hange in Resident Condition d, "Prior to notifying the e provider, the nurse will ervations and gather relevant nation for the provider."				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
00582		00582	B. WING		C 11/04/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	TERVIEW PINES LLC		H STREET SOL A, MN 55792	JTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 11	2 830			
	identified R3 had in	ange MDS dated 8/28/20, ntact cognition. R3's MDS e received diuretic medication en days.				
	R3's care plan lack were to be perform	ted indication daily weights ned.				
	directed R3 was to due to CHF. The o	Iministration record (MAR) have his weight taken daily order was discontinued on f R3's MAR's from 9/1/20, to ollowing:				
	9/10/20, 9/11/20, 9 9/19/20/ 9/23/20, 9 10/14/20, 10/16/20 10/22/20, 10/25/20 and 11/3/20. -Weights were doc	documented on 9/3/20, 9/6/20, /12/20, 9/13/20, 9/18/20, /26/20, 9/29/20,10/6/20, 1, 10/17/20, 10/20/20, 10/21/20 1, 10/29/20,10/30/20, 11/1/20, cumented as refused on 9/5/20 /15/20 and 10/28/20.				
	conducted with R3 staff didn't forgot to didn't refuse to hav	5 p.m. an interview was . R3 stated he believed facility o take his weight. R3 stated he /e his weight taken as /ith my health is important."	•			
	conducted with NA have his weight tak	3 p.m. an interview was -B. NA-B stated R3 was to ken daily. NA-B stated weights in the electronic medical				
	conducted with LP	09 a.m. an interview was N-C. LPN-C stated R3 was to ken daily, however, sometimes				

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMI	E SURVEY PLETED
00582	B. WING			C 04/2020
ER STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		JTH		
NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
<ul> <li>1:19 a.m. an interview was</li> <li>RN-B. RN-B confirmed R3 was his weight taken daily. RN-B redical record and confirmed of weights were missing. RN-B alikely instances where a weight d and subsequently not of the next shift. RN-B she was ghts were not taken, however, appeared to be "repeat e dates in which weights were no N-B stated R3 was not known to sweight taken.</li> <li>2:45 p.m., an interview was he DON. The DON stated two fied as being "offenders" veights. The DON stated one already reeducated. The DON expected to obtain weights, as ment refusals. The DON stated sed, a risk versus benefits ed to be completed.</li> <li>by Resident Weight Evaluation the physician's order, or a een the interdisciplinary team."</li> <li>IETHOD OF CORRECTION: fursing (DON), or designee, could and implementation of . The DON, or designee, could</li> </ul>				
	IDENTIFICATION NUMBER:         00582         IER       STREET A         LC       1201 8TI         VIRGINIZ         STATEMENT OF DEFICIENCIES         ENCY MUST BE PRECEDED BY FULL         OR LSC IDENTIFYING INFORMATION)         Image 12         1:19 a.m. an interview was         RN-B. RN-B confirmed R3 was         his weight taken daily. RN-B         nedical record and confirmed         of weights were missing. RN-B         a likely instances where a weight         d and subsequently not         o the next shift. RN-B she was         ghts were not taken, however,         appeared to be "repeat         e dates in which weights were no         N-B stated R3 was not known to         s weight taken.         2:45 p.m., an interview was         the DON. The DON stated two         fied as being "offenders"         veights. The DON stated one         s already reeducated. The DON         a risk versus benefits         ed to be completed.         y Resident Weight Evaluation         ctare Management Rehabilitation         n an accurate weight of residents         or readmission. Further, weights         r each resident monthly or m	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING:         00582       B. WING         LC       1201 8TH STREET SOU VIRGINIA, MN 55792         STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         119 a.m. an interview was RN-B. RN-B confirmed R3 was his weight taken daily. RN-B bedical record and confirmed of weights were missing. RN-B s likely instances where a weight d and subsequently not o the next shift. RN-B she was ghts were not taken, however, appeared to be "repeat e dates in which weights were not N-B stated R3 was not known to s weight taken.         2:45 p.m., an interview was the DON. The DON stated one s already reeducated. The DON e expected to obtain weights, as ument refusals. The DON stated ised, a risk versus benefits ed to be completed.         y Resident Weight Evaluation cted, "It is the policy of all care Management Rehabilitation n an accurate weight of residents or readmission. Further, weights r each resident monthly or more to the physician's order, or a teen the interdisciplinary team."         METHOD OF CORRECTION: nursing (DON), or designee, could e policies/procedures related to ment and implementation of s. The DON, or designee, could lementation of policy, care plans,	(X1) PROVIDER/SUPPLER/CLA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING:         00582       B. WING         ER       STREET ADDRESS, CITY, STATE, ZIP CODE         LC       1201 8TH STREET SOUTH VIRGINIA, MN 55792         STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)       PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL PRESE       PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC         IP age 12       2 830         1:19 a.m. an interview was RN-B. RN-B confirmed R3 was his weight taken daily. RN-B tedical record and confirmed of weights were mostsing. RN-B s likely instances where a weight d and subsequently not o the next shift. RN-B she was phts were not taken, however, appeared to be "repeat e dates in which weights were not N-B stated R3 was not known to s weight taken.         2:45 p.m., an interview was the DON. The DON stated two fied as being "offenders" veights. The DON stated one s already reeducated. The DON s already reeducated. The DON s already reeducated. The DON s already reeducated. The DON s already reducated. The DON s are amagement Rehabilitation n an accurate weight of residents or readmission. Further, weights r each resident monthly or more to the physician's order, or a een the interdisciplinary team."         /// ETHOD OF CORRECTION: mursing (DON), or designee, could e policies/procedures related to ment and implementation of s. The DON, or designee, could e policies/procedures related to ment and implementation of s. The DON, or designee, could ementation of policy, care plans,	(X1) PROVIDER/SUPPLIER/CLA DENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING:       (X3) DATE COM         00582       B. WING       11//         ER       STREET ADDRESS, CITY, STATE, ZIP CODE       11//         IC       1201 8TH STREET SOUTH VIRGINIA, MN 55792       11//         STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL RLSC DEVITY/NG INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         ipage 12       2 830       2 830         1:19 a.m. an interview was RN-B. RN-B. RN-B confirmed R3 was his weight taken daily. RN-B redical record and confirmed of weights were missing. RN-B slikely instances where a weight and subsequently not o the next shift. RN-B she was plits were not taken, however, appeared to be "repeat e dates in which weights were not N-B stated R3 was not known to s weight taken.         2:45 p.m., an interview was the DON. The DON stated one s already reeducated. The DON stated no babin weights, as ument refusals. The DON stated sed, a risk versus benefits at to be completed.         y Resident Weight Evaluation ted, "It is the policy of all care Management Rehabilitation n an accurate weight of residents or readmission. Further, weights r each resident monthly or more to the physician's order, or a een the interdisciplinary team."         AETHOD OF CORRECTION: uursing (DON), or designee, could lementation of policy, care plans,

Minnesota Department of Health STATE FORM

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED
		00582	B. WING		C 04/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	
	<b>ERVIEW PINES LLC</b>	1201 8TH	STREET SC	ОЛТН	
		VIRGINIA,	MN 55792		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 830	Continued From pa	ge 13	2 830		
	could perform rando compliance.	om audits to ensure			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			
21375	MN Rule 4658.0800 Program	) Subp. 1 Infection Control;	21375		12/4/20
	home must establis	on control program. A nursing th and maintain an infection signed to provide a safe and nt.			
	by: Based on observati review, the facility fa was completed duri	ent is not met as evidenced on, interview, and document ailed to ensure hand hygiene ing incontinence cares to amination for 1 of 3 residents owel and bladder		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	
	R5's diagnoses incl behavioral disturbat R5's quarterly Minir 10/8/20, identified F cognition. R5's MD totally dependent up	port dated 11/4/20, indicated uded dementia with nce. num Data Set (MDS) dated R5 had severely impaired S further identified she was pon staff for toileting, and was of bowel and bladder.		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	
	R5's care plan date experienced bowel	d 7/12/20, indicated R5 and bladder incontinence. The staff to provide incontinence		the Hand Hygiene Policy and Procedure, Transmission based precautions and caring for and disinfecting medical equipment. Resources from CDC and	

If continuation sheet 14 of 17

Minneso	ota Department of He	alth			FURM	APPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		00582	B. WING		C 11/04	4/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
		1201 8TH	STREET SO	ОЛТН		
THE WA	TERVIEW PINES LLC	VIRGINIA	, MN 55792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 14	21375			
	care after each inco On 11/4/20, at 10:3 (NA)-C entered R5' put on a pair of glov from a wheelchair to ceiling lift. NA-C low unfastened R5's so NA-C grabbed wet area, and disposed can. NA-C stated R R5 to reach for a si back and rolled R5 exposed portion of product to wipe stoc then partially rolled product, and pulled soiled incontinence bed. NA-C obtaine cleaned R5's buttoo on the soiled incont R5's bed. NA-C dis incontinence produc changing gloves or NA-C obtained a cle partially placed it ur to roll on her back a NA-C touched R5's shoulder, and briefl soiled gloved hand. and assisted R5 rol on her back with her pulled the clean inc R5, and pulled dow soiled gloved hands NA-C reached for th stated, "I would like did not perform har gloves. R5 grabbed	-		MDH will be utilized for the re-edu The DON, Infection Preventionist Clinical Education Coordinator will return demonstration competencia proper hand hygiene with all staff maintain a log with results. Date of Compliance: 12/4/2020 Recurrence will be prevented by: The DON, Infection Preventionist other leadership staff will conduct on all shifts, every day for one we assure proper infection control pra are being followed including hand The results of the audits will be sh with the facility QAPI Committee a based on the results, the audits w continue daily or decrease in num be discontinued once 100% comp demonstrated. Corrections will be monitored by: DON and Infection Preventionist	and l conduct es on and audits ek to actices hygiene. hygiene. ared and ill bers and	

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	COMI	E SURVEY PLETED
		00582	B. WING		11/0	04/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
THE WA	TERVIEW PINES LLC		I STREET SOU A, MN 55792	JTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	director of nursing ( The DON instructed clean her hands, ar NA-C walked to R5 hands, and returned gloves. NA-C state the first place." NA incontinence produ- side-to-side and he instructed NA-C to wash her hands. On 11/4/20, at 11:0 conducted with regi stated hand hygiend after performing inc there was a risk for perform hand hygiend after performing inc there was a risk for perform hand hygiend after she pe R5. NA-C stated sl On 11/4/20, at 12:4 conducted with the were expected to w their gloves when m clean area during re it was an infection of The facility policy H directed hand hygiend "After contact with a membranes and bo	<ul> <li>A product. At 10:52 a.m. the (DON) entered R5's room.</li> <li>A NA-C to remove her gloves, and to put clean gloves on.</li> <li>bathroom, washed her</li> <li>d to R5 with additional pairs of ed, "I should have done this in -C finished fastening R5's ct, and R5 was rolled r pants were raised. The DON remove her gloves and again</li> <li>7 a.m. an interview was istered nurse (RN)-B. RN-B e needed to be completed continence cares. RN-B stated contamination if staff failed to ene.</li> <li>2 a.m. an interview was -C. NA-C confirmed she hand hygiene and put on new rformed incontinence cares on he was "nervous."</li> <li>5 p.m. an interview was and change noving from a dirty area to a esident care. The DON stated</li> </ul>		DEFICIENC		
innesota D		sing (DON), or designee, could				

<u>/linnesota Depart</u> TATEMENT OF DEFIC ND PLAN OF CORREC	IENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00582	B. WING			C 04/2020
AME OF PROVIDER C			DRESS, CITY, ST			04/2020
		1201 8TH	STREET SOL			
HE WATERVIEW	PINES LLC		, MN 55792			
PREFIX (EACI	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375 Continue	ed From pa	ige 16	21375			
hand hyg or design on the po designee ensure o	giene need nee, could blicies and e, could de ngoing cor RIOD FOI	riate staff on indications when s to be performed. The DON, educate all appropriate staff procedures. The DON, or velop monitoring systems to mpliance. R CORRECTION: Twenty-one				
nesota Department o	f Health					