STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterview Woods LLC	601 Grant Avenue Eveleth, MN 55734

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on observation, interview and document review, the facility failed to ensure provider orders and care plan interventions were followed for 1 of 2 residents (R37) reviewed for activities of daily living (ADLs). Findings include: R37's quarterly Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition and a diagnosis of dementia. R37 needed set up and clean up assistance with meals and was dependent for bed mobility and transfers. Provider orders dated 4/24/23, identified R37 was on a mechanical soft diet due to difficulty swallowing and chewing. R37's care plan dated 6/19/23, identified R37 was to eat meals with direct supervision and feeding assistance as necessary in the dining room, and had a mechanical soft diet with ground texture and thin liquids. On 10/21/24 at 3:06 p.m., R37 was lying in bed, with the head of bed up at about 30 degrees. R37 was slouched down in the bed so that his shoulders were about halfway down the head of the bed. There was an over-the-bed table at about the height of his chin with a meal tray on it, all the food was gone except for a scoop of mashed potatoes. R37's left thumb was covered in a red substance that was also the color of food that had been in a small bowl. Family member (FM)-A was at his bedside and stated she found him in bed this way when she arrived and this was not typical as he normally ate in the dining room. During an interview on 10/24/24 at 11:36 a.m., nursing assistant (NA)-D confirmed she had worked day shift on 10/21/24 but didn't recall R37 eating a meal in bed, he normally ate in the common area. NA-F was nearby and NA-D called to her to see if she remembered anything about him eating in bed, but she did not remember either. During an interview on 10/24/24 at 11:42 a.m., registered nurse (RN)-B stated R37 was at risk for choking so they would not have him eating in bed alone. RN-B was unsure about this incident, but stated the expectation would be for R37 to be supervised. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/24 at 1:09 p.m., the director of nursing (DON) stated she would not expect a known choking risk to be lying in bed eating. R37 was at risk for aspiration and should be supervised.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on observation, interview, and document review, the facility failed to comprehensively assess and obtain informed consent prior to resident bed rail use for 1 of 1 residents (R39) reviewed for bed rails. Findings include: R39's admission Minimum Data Set (MDS) dated [DATE], identified R39 had intact cognition and a diagnosis included hip fracture. R39 needed moderate assistance with rolling and repositioning. R39's undated care plan lacked information related to the use of bedrails. R39's medical record lacked an assessment for bed rail alternatives, entrapment risk, or informed consent for bed rail use. On 10/21/24 at 3:27 p.m., R39's bed was observed and there was a bedrail attached to the head of the bed on both sides. During an interview on 10/24/24 at 11:02 a.m., registered nurse (RN)-A stated if bed rails are needed, the resident would be assessed using the Bed Mobility Devise Evaluation form. The form included evaluation if resident ability to use, interventions utilized before bedrails, and fall and injury risk. RN-A stated the from was done on all residents prior to placement of bedrails. RN-A confirmed R39 had bedrails on bilateral sides of the head of bed. RN-A reviewed R39's medical record and acknowledged there was no assessment or consent forms in his chart, which indicated they had not been done. During an interview on 10/24/24 at 2:20 p.m., the director of nursing (DON) stated an expectation all staff that perform assessments would do a mobility devise assessment and obtain consent from the resident prior to placing a bedrail on the bed. The facility bedrail use policy was requested but not provided.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 45842 Based on interview and document review the facility failed to have 8 hours of continuous registered nursing coverage on a daily basis. This had the potential to affect all residents residing in the facility. Findings include: The Centers for Medicare and Medicaid Services' (CMS) Payroll Based Journal (PBJ) Staffing Data Report, identified during the third quarter of 2024 (4/1/24 - 6/30/24) the facility failed to have 8 hours of registered nurse (RN) coverage on the following dates: 4/6, 4/7, 4/20, 4/21, 4/27, 4/28, 5/19, 5/25, 5/26, 6/1, 6/2, 6/8, 6/9, and 6/22. During an interview on 10/24/24, at 2:28 p.m., the administrator confirmed the facility did not have 8 hours of continuous RN coverage on the dates identified on the PB&J report. The administrator stated it was important to have an onsite RN for 8 continuous hours every day for safety of the residents. The facility's scheduling policy and RN coverage policy was requested but not provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49878 Based on interview and document review, the facility failed to ensure a resident with an allergy to shellfish was not served shellfish for 1 of 1 resident (R209) reviewed for food allergies. The resident was fed a dinner containing shellfish, had an allergic reaction, and was sent to the emergency department (ED) for treatment. The deficient practice was identified as an immediate jeopardy (IJ) situation, however, the provider had implemented corrective action prior to the investigation, therefore, the deficiency is issued as past non-compliance. The IJ began on 10/13/24 at 5:15 p.m. when R209 was served, and consumed, shrimp. R209 complained of numbness of the tongue and lips and was sent to the ED for treatment of allergic reaction. The administrator and director of nursing (DON) were informed of the IJ on 10/24/24 at 11:13 a.m. The facility implemented corrective action on 10/14/24, prior to the start of the survey, therefore, was past non-compliance. Findings include: R209's undated face sheet identified he was admitted to the facility on [DATE]. R209's admission note dated 10/9/24, identified he had an allergy to shellfish. R209's care plan dated 10/9/24, identified he had an allergy to shellfish. Progress note dated 10/13/24 at 10:26 p.m., identified R209 had been sent to the emergency room for an allergic reaction to shellfish. Note also identified kitchen staff were notified of the shellfish allergy. Progress note dated 10/14/24, from the culinary director (CD), identified R209's meal ticket was now updated to show allergy to shellfish. R209's shellfish allergy was not on his meal ticket prior to this date. On 10/21/24 at 2:52 p.m., R209 stated he was served shellfish while at the facility, which he was allergic to. On 10/23/24 at 1:02 p.m., R209 stated he had suffered an anaphylactic reaction (severe, life-threatening allergic reaction) after eating shellfish when he was younger that required him to receive epinephrine to counteract his allergic reaction. On 10/23/24 at 10:57 a.m., nursing aide (NA)-A stated resident food allergies should be listed on the resident's meal ticket and in the electronic medical record (EMR) banner. On 10/23/24 at 11:03 a.m., registered nurse (RN)-A described the process for communicating food allergies for new admissions. Health unit coordinator (HUC) receives admission information for new residents and enters allergies into the EMR. The nurse managers verify allergy information in EMR. HUC then completes a dietary sheet and gives to kitchen staff. (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/23/24 at 11:37 a.m., cook (C)-A stated kitchen staff learn about resident food allergies from the dietary sheet. Kitchen staff then log the resident food allergy in a communication book. Resident food allergies are printed on the resident's meal ticket. On 10/23/24 at 12:00 p.m., CD described how resident food allergies are entered into dietary system. HUC brings dietary sheet to the kitchen staff and kitchen staff note the food allergy in communication book. CD noted staff are expected to review communication book every shift. CD verifies resident food allergies in dietary system, which then produces meal tickets with listed resident food allergies. CD stated she is the only staff that can log in to dietary system and verify/add food allergies. On 10/23/24 at 1:03 p.m., culinary aide (CA)-A stated that floor staff brought the dietary forms down and gave them to culinary staff. The culinary staff would then enter the information into the dietary communication book, so all culinary staff were aware of new residents and their dietary restrictions/allergies. The slip would then go into a bucket for the CD to enter the information into the dietary program. The only person in the kitchen who had access to the dietary program is the CD. On 10/23/24 at 1:04 p.m., NA-B stated resident food allergies are listed on meal tickets and in the resident's care plan. NA-B further stated if the food allergy was not on the meal ticket she would not know about the food allergy unless she looked at the care plan. She further stated she doesn't always check the care plan when passing out meal trays. On 10/23/24 at 1:11 p.m., licensed practical nurse (LPN)-A stated a resident's food allergy would be on the meal ticket and also on EMR banner. On 10/23/24 at 1:12 p.m., RN-B stated resident food allergies should be on meal ticket and in the resident care plan. RN-B further stated she can not log into dietary system to add food allergies to the meal tickets. On 10/23/24 at 1:14 p.m., NA-C stated resident food allergies are typically listed and highlighted on meal tickets. During interview on 10/24/24 at 8:59 a.m., nurse practitioner (NP) stated allergic reactions to food can range from an upset stomach to anaphylaxis. NP also stated if a resident has a history of anaphylaxis to a food allergy, the resident could have the same severe reaction if exposed to that same food allergen. On 10/23/24 at 3:58 p.m., the director of nursing (DON) stated the nurse working the evening of 10/13/24 called her first and then she called the administrator, all around 5:40 p.m. The administrator and DON confirmed R209's anaphylactic allergy, learned he had a scratchy throat, his tongue was numb, and he was sent to ED. The administrator and DON called the dietary director that evening and an investigation ensued. Event was reported to the state agency within two-hour time frame. All residents with food allergies were reviewed for accuracy. The corporate regional dietary director and nursing consultant were involved in a meeting with the leadership team to determine a root cause. The root cause was identified as a dietary sheet that was lacking a place for allergies, therefore was not communicated to the kitchen staff upon R209's admission and lead to the resident being served shrimp. Facility policies were reviewed and did require revisions. The DON had completed an audit on the only admission they have had since this incident. (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility document Waterview Woods Fall/Winter 2024-2025, identified the evening meal on 10/13/24 was seafood pasta alfredo, buttered peas, apricots. The alternative meal for 10/13/24 was garden vegetable soup or hamburger on a bun. The facility implemented corrective action to prevent recurrence by 10/14/24, when the facility implemented a systemic plan that included the following actions: On 10/13/24, all residents were audited for current food allergies. On 10/14/24, the new admission form was modified to add an area specifically to address resident food allergies, dietary policy related to meal tickets was reviewed, resident allergy documentation was reviewed, and staff were educated on the meal ticket handling policy and what to do with new admissions form. Audits did not result in further discrepancies. This was verified through observation, interview, and document review.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49878 Based on interview and document review, the facility failed to offer and provide a substantive snack after dinner and before bedtime, when there were 15 hours between the evening and morning meals. This had the potential to affect all residents in the facility. Findings include: During interview on 10/23/24 at 11:45 a.m., cook (C)-A stated dietary staff bring snacks to the unit and restock fridges. C-A further stated nursing staff were responsible for giving snacks to the residents. R8's quarterly Minimum Data Set (MDS) dated [DATE] identified intact cognition and diagnoses of Parkinson's disease and type II diabetes mellitus. During a resident council meeting on 10/24/24 at 1:23 p.m., R8 stated there was no evening snack pass and further stated the kitchen closed at 7 p.m. each evening. R8 confirmed there was not a snack cart, and residents have to request a snack to get one. The unit fridges always have sandwiches but they are locked at night and they cannot get a snack without asking staff. During interview on 10/24/24 at 1:40 p.m., licensed practical nurse (LPN)-B identified she worked both day and evening shifts. LPN-B stated the kitchen sends snack to the unit. LPN-B further stated there was no evening snack cart and staff did not offer snacks to residents. During interview on 10/24/24 at 1:43 p.m., LPN-C stated she worked both day and evening shifts. LPN-C stated there were many options for snacks on the unit. LPN-C further stated residents have to ask for a snack, and staff do not have a snack cart anymore. LPN-C stated she did not know why the snack cart was stopped. The Waterview Woods LLC Mealtimes document identified breakfast as being served at 8:00 a.m. and dinner at 5:15 p.m. Taking into consideration there may not be more than 14 hours between meal services unless a substantial bedtime snack is offered, all residents will have available to them, a bedtime snack. Adequacy of the snack would be determined by individuals in the group and evaluation of the overall nutritional status of those in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on observation, interview, and document review, the facility failed to ensure staff properly utilized personal protective equipment (PPE) for 1 of 3 residents (R37) reviewed for enhanced barrier precautions (EBP). In addition, the facility failed to annually review the infection control policy and procedures, ensure a current list of reportable communicable diseases was a part of the program, perform infection surveillance of staff members, test staff members during a COVID-19 outbreak, and to provide evidence-based surveillance criteria to define infections to licensed nursing staff. This had the ability to affect all residents who reside at the facility. Findings for R37 include: R37's quarterly Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition and a diagnosis of post-colostomy (a surgery where part of the intestine is cut and reattached to form an opening on the abdomen where a collection bag holds the stool) status. R37 was dependent on staff for turning, repositioning, colostomy care, toileting, and hygiene. R37's provider orders dated 4/29/24, identified EBP when providing ostomy care and other high contact care activities. R37's care plan dated 4/29/24, identified EBP for staff when providing high contact cares. During an observation on 10/22/24 at 4:04 p.m., nursing assistant (NA)-E and NA-F entered R37's room to provide repositioning. NA-F looked at the EBP sign on the door and told NA-E they needed to put gloves on. Both NAs donned gloves and proceeded to roll R37 onto his left side and used a pillow to prop behind him, and then boosted him up in the bed. NA-E and NA-F doffed their gloves and washed their hands with soap and water. During an interview, NA-F stated the precautions were only for R37's wounds and not for COVID-19, so they didn't need to wear full PPE because they were not providing wound care and he didn't have COVID-19. During an interview on 10/24/24 at 11:42 a.m., registered nurse (RN)-B stated it would be her expectation for NAs to wear required PPE, including a gown and gloves, when providing care to a resident on enhanced barrier precautions. RN-B stated the NAs were educated about the precautions and necessary PPE. This was important for infection control. During an interview on 10/24/24 at 1:09 p.m., the DON stated she would expect staff to use PPE when repositioning a resident with enhanced barrier precautions to help reduce the transmission of bacteria. Findings for COVID-19 outbreak testing, annual review of policy and procedure, listing of reportable communicable diseases, infection surveillance of staff members, and infection surveillance criteria include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The centers for Disease Control (CDC) Infection Control Guidance: SARS-CoV-2 dated 6/24/24 identified guidance for nursing homes experiencing an outbreak, or single new case of SARS-CoV-2, to approach the outbreak through either contact tracing or broad-based testing. Contact tracing may be sufficient if all potential contacts can be identified. Perform testing for all residents and health care personnel identified as close contacts regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative. This will typically be at day one (day of exposure counts as day zero), day three, and day five. During an interview on 10/21/24 at 5:30 p.m., the director of nursing (DON) confirmed the facility had two current positive resident cases of COVID-19. The DON reports having done contact tracing and finding the source outside of this building, no other residents or staff have reported symptoms and no testing of staff had been done. At 5:39 p.m., the DON confirmed there were no signs on the main doors indicating active infection or criteria for passive screening. During an interview on 10/24/24 at 1:18 p.m., regarding the current COVID-19 outbreak, the DON stated she had touched base with everyone who had worked with the two positive residents, and they didn't have any symptoms, so they had not been tested . She couldn't say for sure none of the staff had 15 minutes or more with the residents over the course of their shift and provided the 15 minutes could be an accumulation of shorter visits. Regarding infection surveillance, the DON stated she didn't do any surveillance of staff signs or symptoms of illness. Regarding the annual review of the IP program, the DON stated the management company was responsible for making changes to policies and procedures and making sure they were up to date. Regarding McGreer's Criteria, or similar, the DON stated they tried to use the McGreer's criteria but there wasn't a form or guide for nurses. During an interview on 10/24/24 at 2:15 p.m., licensed practical nurse (LPN)-C stated she was not aware of any kind of SBAR or McGreers criteria to define infection, but just generally knew the signs and symptoms of things like a urinary tract infection. LPN-D was in the area of this conversation and confirmed she didn't know of any criteria to look at before requesting an order for a test of some kind. On 10/28/24 the facility provided a report created on 10/28/24, identifying staff names and results for COVID-19 testing on 10/18, 10/19, and 10/21/24. However, based on the above interviews the DON had previously confirmed COVID-19 testing had not been completed on staff. Monarch Health Management (MHM) Infection Prevention and Control Program dated 3/13/23, identified the facility had established policies and procedures regarding infection control among employees, contractors, vendors, visitors, and volunteers. The program didn't address infection surveillance for these groups. MHM Antibiotic Stewardship Program dated 3/13/23, identified prior to calling a provider to communicate a suspected infection, the nurse will obtain and have available the signs and symptoms of suspected infection based on McGreers criteria. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	MHM COVID Policy dated 3/7/24, identified the facility follows current Centers for Disease Control (CDC) guidelines. The policy indicates all facility testing needed to be documented and kept by the facility infection preventionist. All residents and staff need to be tested per the guidelines that prompted te testing. The policy contains a testing summary which identified newly identified COVID-19 positive staff or resident who can identify close contacts, should trigger testing of all staff regardless of vaccination status that had a higher-risk exposure with a COVID-19 positive individual. The policy defined an outbreak as a single new case of COVID-19 in a resident and indicated testing should begin immediately. Testing may be through contact tracing or broad-based testing.