



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 11, 2026

Administrator
The Waterview Pines LLC
1201 8TH STREET SOUTH
PO BOX 971
VIRGINIA, MN 55792

RE: CCN: 245283

Cycle Start Date: January 15, 2026

Dear Administrator:

On February 4, 2026, we notified you a remedy was imposed. On March 4, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 13, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 15, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 4, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 15, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 13, 2026, 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 Therefore, the NATCEP prohibition is rescinded.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 Location may notify you of their determination regarding any imposed remedies.

Your request for a continuing waiver involving the deficiency(ies) cited under K521 - HVAC at the time of the January 15, 2026, standard abbreviated extended survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Sarah Lane".

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



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March 11, 2026

Administrator
The Waterview Pines LLC
1201 8TH STREET SOUTH
PO BOX 971
VIRGINIA, MN 55792

Re: Reinspection Results
Event ID: 1DDFD1-H2

Dear Administrator:

On February 25, 2026, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 15, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

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An equal opportunity employer.



Protecting, Maintaining and Improving the Health of All Minnesotans

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February 5, 2026

Administrator
The Waterview Pines LLC
1201 8TH STREET SOUTH
PO BOX 971
VIRGINIA, MN 55792

RE: CCN: 245283

Cycle Start Date: January 15, 2026

Dear Administrator:

On January 15, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (level F), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (level F), whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

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 location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 15, 2026

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 15, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 15, 2026.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 15, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

DEPARTMENT CONTACT

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

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.

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 July 15, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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
202-795-7490

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 at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the

cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

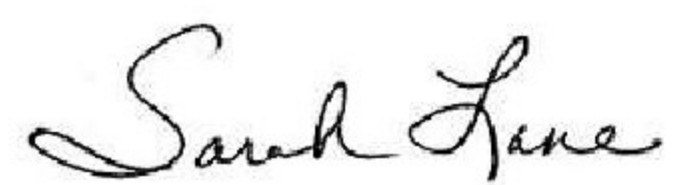
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



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February 5, 2026

Administrator
The Waterview Pines LLC
1201 8TH STREET SOUTH
PO BOX 971
VIRGINIA, MN 55792

Re: State Nursing Home Licensing Orders

Event ID: 1DDFD1-H1

Dear Administrator:

The above facility survey was completed on January 15, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

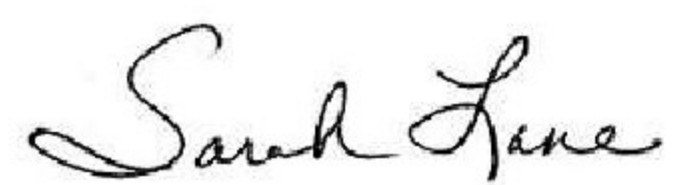
Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/15/2026	
NAME OF PROVIDER OR SUPPLIER The Waterview Pines LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH PO BOX 971, VIRGINIA, Minnesota, 55792			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E0000	Initial Comments On 1/12/26 to 1/15/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			02/13/2026	
F0000	INITIAL COMMENTS On 1/12/26 to 1/15/26, a standard recertification survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H: 52838244C (2674456) H: 52833360C (2683072) H: 52833361C (2668540) H: 52833362C (2605737) H: 52273363C (1193172) MN: 00109532 H: 52833364C (2584739) with citations. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.		F0000			02/13/2026	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER The Waterview Pines LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH PO BOX 971, VIRGINIA, Minnesota, 55792	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	Continued from page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		
F0577 SS = C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the past three years of recertification and complaint survey results were available for review. This had the potential to affect all 67 residents residing in the facility, as well as family, visitors and staff. Findings include: On 1/12/26, at 7:27 p.m., a review of the survey binder	F0577	F0557 Rights to Survey Results/Advocate Agency Info Immediate Corrective Action: Survey result binder update. Corrective Action as it applies to others: Resident Rights reviewed. Education provided to administrator and administrator assistant on resident rights regarding survey result binder. Date of Compliance: 2/13/26 Recurrence will be prevented by: Survey result binder will be checked to ensure the past 3 years of recertification and complaint survey results are available for review weekly x4 weeks then monthly x2. These results will be shared with the facility QAPI committee to increase, decrease, or discontinue audits. Corrections will be monitored by: Administrator or Designee	01/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/15/2026	
NAME OF PROVIDER OR SUPPLIER The Waterview Pines LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH PO BOX 971, VIRGINIA, Minnesota, 55792			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0577 SS = C	Continued from page 2 was completed. Upon review of the survey binder, it was noted that all required recertification surveys, as well as complaint investigation surveys were present, with the exception of the recertification and complaint surveys for the year 2023. During an interview on 1/13/26 at 3:34 p.m., the administrator stated there should be three years of recertification and complaint surveys available for all residents, family and visits to view when wanted. the administrator stated she had just gone through the survey binder a month ago and made sure all needed surveys were in the binder. During an interview on 1/13/26 at 3:48 p.m., the corporate administrator reviewed the survey binder and confirmed all surveys from 2023 were missing and should be in there. A facility policy about the survey binder was requested but not provided.		F0577				
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical		F0605	F0605 Right to be free from Chemical Restraints Immediate Corrective Action: R9's orders for her prn psychotropic medication were updated with a stop date. Corrective Action as it applies to others: Psychotropic Medication Use policy reviewed. All residents with prn psychotropic medications were reviewed to ensure they have a stop date. All clinical leaders will be educated on stop dates for prn psychotropic medications. Date of Compliance: 2/13/2026 Recurrence will be prevented by: 5 residents will be evaluated to ensure their PRN		02/13/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/15/2026	
NAME OF PROVIDER OR SUPPLIER The Waterview Pines LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH PO BOX 971, VIRGINIA, Minnesota, 55792			
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F0605 SS = D	Continued from page 3 symptoms. §483.12(a) The facility must- . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication		F0605	Continued from page 3 psychotropic medications have a stop date weekly x4 weeks then monthly x2. These results will be shared with the facility QAPI committee to increase, decrease, or discontinue audits. Corrections will be monitored by: Administrator or Designee			

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NAME OF PROVIDER OR SUPPLIER The Waterview Pines LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH PO BOX 971, VIRGINIA, Minnesota, 55792			
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F0605 SS = D	Continued from page 4 is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based interview and record review the facility failed to ensure psychotropic PRN (as needed) medication orders were timed limited to a duration of 14 days for 1 of 5 residents (R9) who was reviewed for psychotropic medications. Findings include: R9's quarterly Minimum Data Set (MDS) dated 10/24/25, indicated R9 was cognitively intact with diagnoses of anxiety disorder, major depression, diabetes, and chronic diastolic heart failure. MDS section N. indicated R9 received high risk anti-anxiety medications. R9's facility provided undated Care Plan identified focus areas and interventions to support and monitor R9's behavior and mental health needs related to diagnoses of depression, anxiety, insomnia.			F0605			

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F0605 SS = D	Continued from page 5 Upon entering the facility on 1/12/26 R9's electronic medical record (EMR) orders included the order: alprazolam take 0.5mg every 24 hours as needed (PRN) for increased anxiety. The ordered date was 9/15/20/25. The order did not have a stop date. Pharmacy Consult Recommendations included: -10/22/25: the resident has order for alprazolam 0.5 mg give one tab as needed q 24-hour prn without stop date. Please consider discontinuation or add stop date per CMS regulation. Provider documented response: disagree pt is stable at current dose will reevaluate at next appt. -9/17/25: alprazolam no stop date. Please consider add stop date or discontinuation per CMS SOM. Provider response on 9/23/25 requested follow-up with range mental health who manages med During an interview on 1/15/26 at 11:54 a.m., clinical manager licensed practical nurse (LPN-A) stated R9's alprazolam order needed to have a new script every 14 days. LPN-A stated they did notify the provider to send a new script to the pharmacy every 12 days. They tracked the notification in a calendar but did not enter any orders into the EMR or have record of orders they had requested the provider send to the pharmacy. During an interview on 1/15/26 at 11:58 a.m., the director of nursing stated all PRN psychotropic medications needed to have stop date every 14 days for provider review and reorder if needed. R9 should have had a stop order and a renewal order for their alprazolam. Nurse consultant was present and stated their facility policy allowed nursing to stop PRN medication at 14 days to trigger the provider to reorder the medication. The facility policy Psychotropic Medication Use dated 5/2025, outlined the following instruction for the use of PRN psychotropic use: psychotropic PRN medications are to be used to address acute or intermittent symptoms, or in an emergency and are limited to 14 days. If a provider believes the PRN order should be extended beyond 14 days, the provider must document rationale and duration in the medical record.		F0605				
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)		F0657	F0657 Care Plan Timing and Revision		02/13/2026	

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F0657 SS = D	Continued from page 6 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to review and revise the resident care plan to include chemotherapy, breathing problems and oxygen use for 1 of 3 residents (R31) reviewed for care planning. R31's quarterly minimum data set (MDS), dated 11/18/25, identified a diagnosis of congestive heart failure (CHF), rectal cancer, and atrial fibrillation. R31's care plan, dated 12/11/25, didn't contain a focus statement for coordination and care of R31's chemotherapy treatments, breathing problems or oxygen use. R31's provider orders, dated 1/12/26, didn't contain orders for oxygen use or the care and keeping of oxygen	F0657	Continued from page 6 Immediate Corrective Action: R31's care plan was updated to include chemotherapy, breathing problems, and oxygen use. Corrective Action as it applies to others: All resident care plans were reviewed to ensure appropriate information pertaining to the residents' diagnosis and orders were on the care plan. All clinical leaders will be educated on reviewing and revising care plans to ensure they are accurate and complete. Date of Compliance: 2/13/26 Recurrence will be prevented by: 5 residents care plans will be reviewed to ensure appropriate information pertaining to diagnosis and orders are up to date weekly x4 weeks then monthly x2. These results will be shared with the facility QAPI committee to increase, decrease, or discontinue audits. Corrections will be monitored by: Administrator or Designee	

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F0657 SS = D	Continued from page 7 equipment. R31's Weights and Vitals Summary identified R31 was wearing oxygen via nasal cannula on dates when oxygen saturation levels were recorded starting on 10/29/25 through 1/15/26. R31's provider progress note dated 10/29/25, identified new orders related to CHF: repeat chest x-ray next week, monitor vital signs every shift for two weeks, monitor oxygen saturation every shift daily and as needed for two weeks, if 90 percent or less update provider, oxygen use during the day at two liters per minute (LPM) via nasal cannula while on chemotherapy, make sure oxygen is on at one LPM during the night. A provider progress note from 11/5/26, identified to continue to monitor oxygen use at two LPM via nasal cannula every shift, resident occasionally has nasal cannula not in nostrils. During an observation and interview on 1/12/26 at 3:35 p.m., R31 was observed wearing an oxygen cannula on his nose, the oxygen concentrator was set at one liter per minute (LPM) and R31 stated he wore oxygen daily. During an observation on 1/14/26 at 7:10 a.m., R31 was in bed sleeping, oxygen cannula was on his nose, and the concentrator was running. During an interview on 1/14/26 at 12:23 p.m., licensed practical nurse (LPN)-B stated R3 occasionally wore oxygen. During an interview on 1/14/26 at 2:36 p.m., the director of nursing (DON) stated continuous and as needed (PRN) oxygen should have orders for them. The DON also stated she thought R31 had an order for oxygen because they were working on weaning him down and making sure his saturations stayed in an acceptable range. During an interview on 1/15/26 at 9:23 a.m., physical therapy assistant (PTA)-E confirmed he had been working with R31 since his admission, and R31 had been wearing oxygen when PTA-E was working with him, he thought R31 was currently on one LPM and checked his oxygen saturation levels while working with him. During an observation on 1/15/26 at 9:33 a.m., R31 was wearing oxygen via nasal cannula connected to an oxygen concentrator. During an interview on 1/15/26 at 10:28 a.m., LPN-A who was the clinical manager for R31, stated she would want		F0657				

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F0657 SS = D	Continued from page 8 orders in place if the resident was using oxygen. LPN-A confirmed R31's medical record didn't contain orders for oxygen.	F0657		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident who was unable to perform their own activities of daily living (ADL)s received nail care for 1 of 3 residents (R44) reviewed for ADLs. R44's quarterly minimum data set (MDS), dated 1/8/26, identified significant cognitive impairment and a diagnosis of late-onset Alzheimer's dementia. The MDS further indicated R44 was dependent in all ADLs. R44's care plan, dated 8/6/25, identified a focus statement for assistance with ADLs related to dementia, osteoarthritis, weakness and falls. Interventions included an assist of one with all ADL tasks including nail care, specifically to trim fingernails and toenails as needed on shower days. The care plan didn't include podiatry care for her toenails, nor did it address behavior or resistance to having nails trimmed. R44's provider orders, dated 8/6/25, identified an order to check fingernails and toenails once a week and provide nail care every Wednesday. Document in nursing note of any behaviors or refusals. R44's electronic medical record (EMR) didn't contain a progress note related to bathing, nail care or refusals of nail care on Wednesday 1/7/26. An assessment, Weekly Skin Inspection dated 1/7/26, identified R44 had a bath or shower and had her finger and toenails trimmed. During an observation and interview on 1/13/26 at 1:39 p.m., family member (FM)-D stated he was having issues with R44's nails not being taken care of, and unbeknownst to him was removed from the podiatry list so her nails didn't get taken care of. FM-D stated he had looked at R44's feet in the first place because she	F0677	F0677 ADL Care Provided for Dependent Residents Immediate Corrective Action: Nail care completed on R44. Corrective Action as it applies to others: Activites of Daily Living and Maintain Abilities Policy was reviewed. All residents will be assessed to ensure nail care was completed. All staff will be educated on identifying residents who are unable to carry out ADLs that they receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. If staff see services needed, they will report to the clinical managers and/or DON for follow up to be completed. Date of Compliance: 2/13/2026 Recurrence will be prevented by: 5 residents will be checked for appropriate grooming, including nail care, weekly x4 weeks, monthly x2. These results will be shared with the facility QAPI committee to increase, decrease, or discontinue audits. Corrections will be monitored by: Administrator or Designee	02/13/2026

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F0677 SS = D	Continued from page 9 was complaining of foot pain, and he found the great toes each had about one inch overhang from the end of the toe. FM-D also stated he had told the nursing home in writing to put her back on the podiatry list and he had talked to the administrator about it. At 1:49 p.m., FM-D opened R44's hands, as her fingers were pulled in close to her palm, and remarked her fingernails were at least one-quarter inch long, there was brown matter under some of the nails, other nails appeared to be stained. FM-D stated he didn't like to see them like this and thought they needed a trim. During an interview on 1/13/26 at 3:28 p.m., nursing assistant (NA)-E stated they would be responsible for trimming resident nails for non-diabetics only, the diabetics were done by the nurse. During an interview on 1/13/26 at 3:31 p.m., licensed practical nurse (LPN)-C stated R44's toenails were too thick for them to cut, but they could do her fingernails. During an observation and interview on 1/13/26 at 3:35 p.m., LPN-A, who was the clinical nurse manager for R44, stated R44 screamed bloody murder when they tried to trim her nails, and her family was aware of that. LPN-A stated she would expect nail care was done if it was documented as done. LPN-A looked at R44's fingernails and stated they were long and dirty as well. LPN-A stated she would have expected a nursing note and a notice to herself if R44 were refusing. During an interview on 1/13/26 at 3:58 p.m., the director of nursing (DON) stated she expected resident nails to be trim and clean. The DON explained she would have expected the nurse to have made a note if a resident were refusing care. Activities of Daily Living (ADL)s and Maintain Abilities Policy dated 3/31/23, identified a resident who was unable to carry out ADLs would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.		F0677				
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents		F0684	F0684 Quality of Care Immediate Corrective Action: Oxygen orders obtained for R31. Treatment orders updated for R23.		02/13/2026	

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F0684 SS = D	Continued from page 10 receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure orders were in place for a resident receiving oxygen for 1 of 7 residents (R31). In addition, the facility failed to assess and treat lower extremity edema for 1 of 7 residents (R23) reviewed for quality of care. Findings include: R31: R31's quarterly minimum data set (MDS), dated 11/18/25, identified a diagnosis of congestive heart failure (CHF), rectal cancer, and atrial fibrillation. R31's care plan, dated 12/11/25, didn't contain a focus statement for breathing or oxygen use. R31's provider orders, dated 1/12/26, didn't contain orders for oxygen use or the care and keeping of oxygen equipment. R31's Weights and Vitals Summary identified R31 was wearing oxygen via nasal cannula on dates when oxygen saturation levels were recorded starting on 10/29/25 through 1/15/26. During an observation and interview on 1/12/26 at 3:35 p.m., R31 was observed wearing an oxygen cannula on his nose, the oxygen concentrator was set at one liter per minute (LPM) and R31 stated he wore oxygen daily. During an observation on 1/14/26 at 7:10 a.m., R31 was in bed sleeping, oxygen cannula was on his nose, and the concentrator was running. During an interview on 1/14/26 at 12:23 p.m., licensed practical nurse (LPN)-B stated R3 occasionally wore oxygen. During an interview on 1/14/26 at 2:36 p.m., the director of nursing (DON) stated continuous and as needed (PRN) oxygen should have orders for them. The DON also stated she thought R31 had an order for oxygen because they were working on weaning him down and making sure his saturations stayed in an acceptable range.			F0684	Continued from page 10 Corrective Action as it applies to others: Skin assessment and Wound Management Policy reviewed. All clinical staff education provided for direction for daily skin inspection with cares. All licensed nursing staff education on weekly skin inspection to be completed, implementation of appropriate preventative measures and referrals, notifications and/to update to provider, nurse, and family for new or ongoing skin issues PRN and provide care and treatment as ordered. All clinical managers educated on care plan updating as needed and treatment orders are inputted. Date of Compliance: 2/13/2026 Recurrence will be prevented by: 5 residents will be checks to ensure skin assessments and treatment orders are completed weekly x4 weeks then monthly x2. These results will be shared with the facility QAPI committee to increase, decrease, or discontinue audits. Corrections will be monitored by: Administrator or Designee			

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F0684 SS = D	Continued from page 11 During an interview on 1/15/26 at 9:23 a.m., physical therapy assistant (PTA)-E confirmed he had been working with R31 since his admission, and R31 had been wearing oxygen when PTA-E was working with him, he thought R31 was currently on one LPM and checked his oxygen saturation levels while working with him. During an observation on 1/15/26 at 9:33 a.m., R31 was wearing oxygen via nasal cannula connected to an oxygen concentrator. During an interview on 1/15/26 at 10:28 a.m., LPN-A who was the clinical manager for R31, stated she would want orders in place if the resident was using oxygen. LPN-A confirmed R31's medical record didn't contain orders for oxygen. R23: R23's admit Minimum Data Set (MDS) dated 11/23/25, indicated R23 was moderately cognitively impaired with diagnoses of venous insufficiency, acute respiratory failure, and ischemic cardiomyopathy. R23's undated facility provided Care Plan included focus area: Alteration in skin integrity with interventions: monitor skin during cares, weekly skin inspection by nurse, tubi grips on in a.m. and off in h.s. [bedtime]. R23's Order Summary Report dated as of 1/15/2026, included the following orders: -Tubi grips [material designed to provide compression and reduce swelling] on in a.m., off at H.S. every morning and at bedtime related to acute combined systolic and diastolic congestive heart failure. -Weekly skin inspection by licensed nurse. Complete MHM Weekly Skin In section in PCC every day shift every Thursday. -Orders did not include treatments or lotions for legs. R23's Treatment Administration Record (TAR) for the month of January 2026, had documented entries between 1/1/26 and 1/14/26, were signed off to indicate R23's tubi grips had been put on in the a.m. and removed at bedtime. R23's ordered Weekly Skin Inspection were documented as			F0684			

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F0684 SS = D	Continued from page 12 follows in the electronic medical record (EMR): -11/13/25: "Res skin is dry and intact -11/28/25: did not see skin but NA had her dressed and said there was no issues. edema lower legs -12/10/25: BLE edema, no weeping noted from legs, scabs. No other skin issues noted -12/18/25: Edema bilateral lower extremities which are reddened but not weeping at this time. Dry scaly skin on legs. No other skin issues noted. -12/25/25 Edema bilateral lower extremities which are reddened but not weeping at this time. Dry scaly skin on legs. 12/31/25 entry: No new skin issues. Skin is dry warm and intact -1/8/26 no new skin issues skin is dry warm and intact During an interview on 1/12/2026 at 5:23 p.m., R23 was wearing knee high socks and was seated in a recliner with legs elevated. R23 stated they had bad edema in their legs and indicated their family member (FM-A) was the one who took care of their legs. Their legs had been really big and leaking fluid before, but now the fluid was way down and their legs hurt less. R23 stated they didn't really have any treatments for their legs other than a water pill. During an interview on 1/12/26 at 6:00 p.m., both R23 and FM-A were present. R23 stated FM-A cared for their legs not the nurses. FM-A, was not sure what the nurses did, but confirmed they did care for R23's legs during daily visits. FM-A stated R23's legs still had dryness and edema, and scabs (pointed to several scabs on R23's left leg -skin on leg was dry with flakes of skin) but overall R23's legs were much improved. R23 stated she liked to wear their white socks because they were absorbent and comfortable. FM-A stated they had bought the socks for R23 and indicated they were just cotton, not compression socks. During an observation on 1/13/26 at 9:42 a.m., R23 was seated with white knee-high socks on. During an interview on 1/13/26 at 2:15 p.m., R23 was seated with legs elevated wearing white knee-high socks. R23 stated they had kept their socks on from yesterday, nobody had offered to put tubi grip sock for them this a.m. R23 stated they had worn compression		F0684				

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F0684 SS = D	Continued from page 13 tubi things before but could not recall when they had last worn them. No tubi grips were visible in R23's room or bathroom. During an observation on 1/13/26 at 4:14 p.m., R23 was seated in recliner with the same knee-high socks on. During an observation on 1/14/26 at 7:16 a.m., R23 was seated in recliner, feet up, wearing the same knee-high socks. During an observation on 1/14/26 at 8:06 a.m., R23 remained in room with same knee-high socks on. During an observation on 1/14/26 at 11:58 a.m., R23 was being wheeled down the hall wearing the same white knee-high socks. R23 stated they were off to an appointment. During an interview on 1/14/26 at 3:13 p.m., licensed practical nurse (LPN-B) explained when they initialed something in the TAR it meant the task or treatment had been completed. LPN-B stated they had signed off on R23's tubi grips because they thought that R23 had been wearing them, but now they guessed they had not been on. LPN-B stated it was important for R23 to wear tubi grips because it helped prevent deep vein thrombosis (blood clots). During an interview on 1/14/26 at 3:15 p.m., the director of nursing (DON) stated when a task was signed off in the TAR it meant that task was completed. If a task was refused or not completed, they expected charting would reflect that. During an observation on 1/15/2026 at 9:45 a.m., R23 was seated in their recliner wearing their white knee-high socks. NA-D responded to R23's call-light and assisted R23 to the bathroom. During an after-care interview NA-D stated R23 did not wear tubi grips or anything like that. During an interview on 1/15/26 at 9:55 a.m., R23 was wearing white knee-high socks and stated staff had not offered to put any tubi compression things on them that morning. R23 stated their legs were more swollen today because of their appointment yesterday but overall,			F0684			

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F0684 SS = D	Continued from page 14 they felt their legs were much better. R23 indicated the staff didn't do any treatments to their legs, it was FM-A who had been washing and putting some kind of cream on their legs each day when they visited. During an interview on 1/15/26 at 11:44 a.m., clinical manager LPN-A opened R23's chart and stated R23 was not being tracked in wound care because R23 did not have any active wound treatments. Instead R23's leg issues were being tracked in the weekly skin assessments. LPN-A reviewed documented skin assessments and stated they would expect skin assessments to reflect skin changes like new scabs and ideally old scabs and/or other ongoing skin issues. Details were important to determine improvement or worsening skin status. Although R23 did not have orders for lotion application to dry skin, it was expected that NAs would identify and apply lotion to dry skin as part of their routine care of residents. LPN-A confirmed R23 had an order for tubi grips and confirmed charting showed that R23 had been wearing tubi grips each day in January as ordered. It was important for R23 to wear the tubi grips because of the fluid retention R23 had in their lower legs. LPN-A indicated they were not aware R23 had not been wearing their tubi grips and stated they expected staff to document a task as not done if it was not done and communicate to them if it was ongoing so it could be addressed. During an interview on 1/15/26 at 12:05 p.m., the DON stated they expected skin inspection documentation to include descriptive findings of old and healing wounds as well as any new edema, weeping, scabs, or any other area of concern so the information could be used to implement or change treatments accordingly. When tubi grips are ordered, clinical managers should make sure the tubi grips are in the room and being applied as part of their resident monitoring oversight. Nurses are also responsible to ensure TAR orders are followed and should note if a resident is or is not wearing their tubi grips when they go into the resident's rooms and then document accordingly. The facility policy Skin Assessment & Wound Management dated 2/2025, included direction for daily skin inspection with cares, weekly skin inspection by licensed staff, implementation of appropriate preventive measures and referrals, notification and or update to provider, nurse, and family for new or ongoing skin issues as needed, care plan updating as needed, and to provide care and treatments as ordered.			F0684			
F0689 SS = D	Free of Accident Hazards/Supervision/Devices			F0689	F0689 Free of Accident Hazards/Supervision/Devices		02/13/2026

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F0689 SS = D	Continued from page 15 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure portable oxygen tanks were safely transported and/or secured for 1 of 2 residents (R23) reviewed for oxygen safety. Findings include: R23's admit Minimum Data Set (MDS) dated 11/23/25, indicated R23 was moderately cognitively impaired with diagnoses of venous insufficiency, acute respiratory failure, and ischemic cardiomyopathy. R23's Care Plan included focus area: Alterations in oxygen/gas exchange with oxygen use as ordered. R23's Order Summary Report dated as of 1/15/2026, included the following orders: Check portable oxygen/stroller every shift and fill if needed, and Oxygen Delivery System via 2LPM nasal cannula continuously for diagnosis acute respiratory failure with hypoxia. R23's Treatment Administration Record for the month of January 2026, had documented entries between 1/1/26 and 1/14/26, that indicated staff had checked R23's portable oxygen/stroller every shift and filled if needed. During an interview on 1/12/2026 at 5:23 p.m., R23 was seated in a recliner. R23's oxygen was connected to a large oxygen concentrator in the room. There was a free standing portable green cylinder oxygen tank located to the left of the concentrator sitting upright and directly on the floor. Both R23 and R23's family member (FM-A) stated the oxygen tank had been directly on the	F0689	Continued from page 15 Immediate Corrective Action: Free standing oxygen tank removed from R23's room. Corrective Action as it applies to others: All clinical staff education provided on safe handling of oxygen tanks. All residents who require oxygen will be checked to ensure the oxygen takes are secured. Date of Compliance: 2/13/2026 Recurrence will be prevented by: 5 residents who require oxygen will be checked to ensure oxygen tanks are secured weekly x4 weeks then monthly x2. These results will be shared with the facility QAPI committee to increase, decrease, or discontinue audits. Corrections will be monitored by: Administrator or Designee	

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F0689 SS = D	Continued from page 16 floor like that for a long time. Nursing assistant (NA-C) delivered R23's dinner tray and left the room. During an oxygen follow-up interview on 1/12/26 at 5:46 p.m., NA-C looked in R23's room and confirmed there was a free-standing unsecured oxygen tank directly on the floor in R23's room and stated they would need to get the RN because it was not safe to have an oxygen tank sitting in the room like that. Registered nurse (RN-B) entered R23's room, picked up the tank and carried it out of the room. During a follow-up interview on 1/12/26 at 6:30 p.m., RN-B stated they had removed the tank from R23's room and secured it in their oxygen storage area because unsecured oxygen created many safety risks. During an interview on 1/15/26 at 11:30 a.m., the director of nursing stated oxygen tanks should not be carried or left unsecured in the building due to the safety risks associated with oxygen tanks. The DON indicated they expected staff to use a wheeled oxygen tank carrier when they transported oxygen tanks. Staff were also expected to ensure oxygen tanks were secured in appropriate holding devices at all times. The facility policy on safe oxygen storage and handling was requested but not received.		F0689				
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to monitor fluid intake for a resident on a fluid restriction and on dialysis. This effected 1 of 2 (R8) residents reviewed for dialysis. Findings include: R8's admission Minimum Data Set (MDS) dated 12/16/25 indicated R8 was cognitively intact. Diagnoses included		F0698	F0698 Dialysis Immediate Corrective Action: R8's intakes were documented in the medical record. Corrective Action as it applies to others: Fluid Restriction Guidelines policy reviewed. All residents on fluid restrictions will be reviewed to ensure they have interventions including fluid restrictions per order. All licensed staff will be educated to follow fluid restrictions and how to properly document fluid intake amounts for each shift.		02/13/2026	

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F0698 SS = D	Continued from page 17 anemia, coronary artery disease, and end stage renal disease. R8 received hemodialysis while at the facility. R8 care plan dated 12/11/25, indicated risk of complications related to dialysis. Interventions included fluid restriction per order. The care plan also indicated a potential alteration in nutrition related to end stage renal disease on a 1500 milliliter (ml) fluid restriction. R8's Order Summary Report (OSR) dated 12/10/25, indicated a provider order for 1500 ml per 24 hours was entered. 600 ml came from nursing and 900 ml came from dietary Review of R8's Treatment Assessment Report (TAR) from 12/10/25 to 1/14/25 indicated there was a fluid restriction of 1500 ml every 24 hours that needed documented on every shift. The TAR also indicated the following: Not applicable (NA) was entered 27 times in December and 15 times in January for nursing and dietary intakes. An "x" was entered two times in December and 6 times in January for nursing and dietary intakes. The spot was left blank 3 times in December and one time in January for nursing and dietary intakes During an interview on 1/14/26 at 11:55 a.m., the dialysis center registered nurse (RN)-A stated R8's dry weights (weights after fluid removed during dialysis) were not getting reached. She had low blood pressures which made it difficult to get all the fluid off. There are several reasons that can cause this, but excess fluid intake is one of them. It is important to accurately monitor R8's fluid restriction because of the need to get all fluid off the patient without compromising the patient. During an interview on 1/15/26 at 10:03 a.m., nurse assistant (NA)-A stated all residents on a fluid restriction would be noted on their care plans. The total amount would be separated by how much nursing gave and how much dietary gave. Nursing would enter the total amount of fluid drank each shift when they were eating in their rooms. The nurse assistant was responsible to keep track of the fluid intakes and give them to the nurse to document in the medical record. NA-A did acknowledge R8 was on a 1500 ml fluid	F0698	Continued from page 17 Date of Compliance: 2/13/2026 Recurrence will be prevented by: 5 resident charts will be viewed to ensure fluid intake amounts are documented weekly x4 weeks then monthly x2. These results will be shared with the facility QAPI committee to increase, decrease, or discontinue audits. Corrections will be monitored by: Administrator or Designee	

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F0698 SS = D	Continued from page 18 restriction. During an interview on 1/15/26 at 10:10 a.m. RN-B stated the aides gathered the fluid intakes for each shift and then gave them to the nurse to enter. The nurse would enter zero of nothing was taken in by nursing or dietary for the shift they were documenting on or enter the exact amount drank if fluid intake occurred. During an interview on 1/15/26 at 10:15 a.m., RN -C stated nursing was responsible for documenting all intakes for the residents in the medical record. There should always be a number entered into each slot on the chart. NA, an "x" and blank spots were not supposed to be there when a resident was on a fluid restriction. During an interview on 1/15/26 at 10:34 a.m. the director of Nursing (DON) stated all staff should be documenting accurate fluid intakes each shift when a resident is on a fluid restriction. Facility policy Fluid Restriction Guidelines last dated 9/12, indicated fluid intakes would be measured every shift per policy of facility.		F0698				
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.-		F0727	"Past Noncompliance - no plan of correction required"		02/13/2026	

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F0727 SS = F	Continued from page 19 §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility ... must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a registered nurse (RN) was scheduled for a minimum of eight hours a day. This had the potential to affect all 67 residents who resided at the facility. This was at past non-compliance do to no RN coverage addressed in the last two quarterly staffing records. Findings include: Review of the facility Staffing Schedules dated 1/1/25 through 6/30/25, revealed there was no RN coverage for the following dates: 1/25/25, 1/26/25, 2/9/25, 3/22/25, 3/23/25, 4/5/25, 4/6/25, 4/19/25, 4/20/25, 5/3/25, 5/4/25, 5/17/25, 5/18/25, 5/26/25, 6/14/25, 6/28/25, and 6/29/25. During an interview on 1/13/26 at 3:43 p.m., the corporate administrator stated the facility had a lot of issues with higher and getting agency staff to work during the first part of the year. The facility was aware there were several days from 1/1/25 through 6/30/25 that did not have RN coverage as required. They daily staffing schedules for 1/1/25 through 6/30/25 were reviewed by the corporate administrator and facility administrator and confirmed there were no RN coverage on the dates listed.Facility staffing policy was requested but not provided.		F0727				
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help		F0880	F0880 Infection Prevention & Control Immediate Corrective Action: Staff involved with cares on 1/13/26 @ 1325 and on 1/14/26 @ 0838 were educated on proper PPE and handwashing.		02/13/2026	

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F0880 SS = D	Continued from page 20 prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.		F0880	Continued from page 20 Corrective Action as it applies to others: Enhanced Barrier Precautions Policy and Handwashing Policy reviewed. All staff will be educated on enhanced barrier precautions and handwashing. Date of Compliance: 2/13/2026 Recurrence will be prevented by: 5 staff will be evaluated to ensure they are using proper infection prevention techniques including EBP and handwashing weekly x4 weeks then monthly x2. These results will be shared with the facility QAPI committee to increase, decrease, or discontinue audits. Corrections will be monitored by: Administrator or Designee			

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F0880 SS = D	Continued from page 21 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to perform appropriate hand hygiene while doing a brief change. The facility also failed to utilize appropriate personal protective equipment (PPE) for a resident in enhanced barrier precautions. This affected 2 of 5 resident (R54, R6) reviewed for infection control. Findings include: R6: R6's significant change Minimum Data Set (MDS) dated 12/13/25, identified he had diagnoses which included chronic obstructive pulmonary disease (a progressive lung condition that blocks airflow, making it hard to breath), right foot drop, spinal stenosis lumbar region with neurogenic claudication (nerve compression in the lower back from a narrowed spinal canal, causing symptoms like leg pain, cramping, numbness, or weakness that worsen with standing/walking), heart failure (the heart can't pump enough oxygen-rich blood to meet the body's needs), hypertension, and opioid dependence. In addition, R6's MDS identified he was cognitively intact and was dependent on staff for assistance with activities of daily living (ADLs). R6's MDS identified he was frequently incontinent of bowel. R6's care plan dated 12/9/25, identified R6 was on enhanced barrier precautions related to wounds and foley catheter. Interventions included to don and doff personal protective equipment when providing high contact cares.		F0880				

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F0880 SS = D	Continued from page 22 R6's Active Orders as of 1/15/26, identified he had orders for enhanced barrier precautions while providing wound cares and other high contact care activities dated 12/9/25. During an observation on 1/13/26 at 1:25 p.m., nursing assistant (NA)-F entered R6's room, with a non-powered manual sit-to-stand transfer aid (NA-F was not wearing an isolation gown). NA-F closed the curtains, lowered the bed, prepared the bed with a lift sheet, put on gloves put did not put on an isolation gown and positioned R6 to use the transfer aid. After assisting R6 into the bed, NA-F gave R6 the call light, removed gloves, performed hand hygiene and took the transfer aid out of the room. NA-G and NA-F entered the room, both donned gloves, no isolation gowns and proceeded to complete a brief change (incontinent of stool). NA-F called for a nurse to check skin and to complete dressing changes. The director of nursing (DON) entered the room, she had gowned and gloved prior to entering the room. The DON performed the dressing changes, doffed the gown and gloves in the room, washed her hands with soap and water and exited the room. NA-F had removed her gloves after the brief change and washed her hands. NA-F put new gloves on and emptied R6's foley catheter. NA-F removed her gloves and performed hand hygiene before exiting the room. During an interview on 1/13/26 at 1:57 p.m., the DON verified the NAs should have been wearing isolation gowns when they were completing personal cares for R6 related to his foley catheter and wounds. Enhanced Barrier Precautions dated 4/1/24, identified "It is the practice of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms." The policy identified staff would wear gowns and gloves during high-contact resident care activities for residents known to be colonized or infected with a multi-drug-resistant organism (MDRO) as well those at increased risk of MDRO acquisition. Examples given were those residents with wounds or indwelling medical devices. High-contact resident cares included transferring, providing hygiene and changing briefs. R54: R54's quarterly Minimum Data Set (MDS) dated 10/10/25, indicated severe cognitive impairment, incontinence of bowel and bladder, and maximal assist to dependent for toileting, hygiene and cares. Diagnoses included		F0880				

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F0880 SS = D	Continued from page 23 non-traumatic brain dysfunction and dementia. During observation on 1/14/26 at 8:38 a.m., nurse assistant (NA)-B entered R54's room to change clothes, do a brief change and get up in chair. NA-B gathered all needed equipment and placed on the bedside table. Hands were washed and clean gloves were placed on hands. The dirty gown was pulled down to the chest level, and the upper body was washed across the shoulders, neck and upper torso. The dirty gown was then completely removed from the resident, and a clean shirt was placed on the resident. Hands were not washed, and gloves were not changed at any time when going from dirty to clean. NA-B then gathered pants and placed them on the resident, pulling just up to the knees, still wearing the same dirty gloves. The brief was removed and peri care performed. Ointment was applied to the buttocks after cleaning. A clean brief was placed under the resident. NA-B removed the right-handed glove and proceeded to complete the brief change, touching the brief and peri area with the ungloved right hand several times. NA-A also came in contact with the dirty linens on the bed with the ungloved right hand. The Glove on the left hand was then removed. Without gloving, NA-B rolled R54 side to side, pulling the pants up the rest of the way, and removed all of the dirty linens under R54 with ungloved hands. New gloves were then put on without washing hands, the lift sling was placed under R54 and R54 was transferred from the bed to the chair. R54 was then taken to the hallway and setup for breakfast. Gloves were removed and hand sanitizer was used at that time. During an interview on 1/14/26 at 10:03 a.m., nurse assistant (NA)-B stated hands should be washed and new gloves put on when going from the dirty part of cares and start of clean part of cares. Gloves should never be removed and cares performed with ungloved hands. NA-B acknowledge she did not change gloves during cares and removed a glove and completed a brief change with an ungloved hand. During an interview on 1/15/26 at 10:03 a.m., the infection preventionist/director of nursing (IP) stated gloves needed to be changed and hands washed anytime they were going from dirty to clean when providing peri care. Example given was when the staff finished brief removal and cleaning of the peri area, hands would need to be washed, and gloves changed before placing the new clean brief on the resident.		F0880				

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F0880 SS = D	Continued from page 24 Facility policy Handwashing Policy last revised 2/24, indicated proper hand-washing techniques would be used to protect the spread of infection. Hand washing would be completed after changing incontinent products or cleaning up after someone who has used the toilet. The policy lacked information about hand hygiene when doing cares and placing clean items on right away.			F0880			

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/12/26 to 1/15/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.			20000			02/13/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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20000	Continued from page 1 The following complaints were reviewed: H:52838244C (2674456) H:52833360C (2683072) H:52833361C (2668540) H: 52833362C (2605737) H: 52273363C (1193172) MN: 00109532 H: 52833364C (2584739) licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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.		20000				
20270	Use of Oxygen		20270	Corrected		02/13/2026	

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20270	Continued from page 2 CFR(s): MN Rule 4658.0090 A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure portable oxygen tanks were safely transported and/or secured for 1 of 2 residents (R23) reviewed for oxygen safety. Findings include: R23's admit Minimum Data Set (MDS) dated 11/23/25, indicated R23 was moderately cognitively impaired with diagnoses of venous insufficiency, acute respiratory failure, and ischemic cardiomyopathy. R23's Care Plan included focus area: Alterations in oxygen/gas exchange with oxygen use as ordered. R23's Order Summary Report dated as of 1/15/2026, included the following orders: Check portable oxygen/stroller every shift and fill if needed, and Oxygen Delivery System via 2LPM nasal cannula continuously for diagnosis acute respiratory failure with hypoxia. R23's Treatment Administration Record for the month of January 2026, had documented entries between 1/1/26 and 1/14/26, that indicated staff had checked R23's portable oxygen/stroller every shift and filled if needed. During an interview on 1/12/2026 at 5:23 p.m., R23 was seated in a recliner. R23's oxygen was connected to a large oxygen concentrator in the room. There was a free standing portable green cylinder oxygen tank located to the left of the concentrator sitting upright and directly on the floor. Both R23 and R23's family member (FM-A) stated the oxygen tank had been directly on the floor like that for a long time. Nursing assistant (NA-C) delivered R23's dinner tray and left the room. During an oxygen follow-up interview on 1/12/26 at 5:46 p.m., NA-C looked in R23's room and confirmed there was a free-standing unsecured oxygen tank directly on the floor in R23's room and stated they would need to get		20270				

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20270	Continued from page 3 the RN because it was not safe to have an oxygen tank sitting in the room like that. Registered nurse (RN-B) entered R23's room, picked up the tank and carried it out of the room. During a follow-up interview on 1/12/26 at 6:30 p.m., RN-B stated they had removed the tank from R23's room and secured it in their oxygen storage area because unsecured oxygen created many safety risks. During an interview on 1/15/26 at 11:30 a.m., the director of nursing stated oxygen tanks should not be carried or left unsecured in the building due to the safety risks associated with oxygen tanks. The DON indicated they expected staff to use a wheeled oxygen tank carrier when they transported oxygen tanks. Staff were also expected to ensure oxygen tanks were secured in appropriate holding devices at all times. The facility policy on safe oxygen storage and handling was requested but not received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures regarding oxygen safety. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20270				
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by:		20570	Corrected		02/13/2026	

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20570	Continued from page 4 Based on observation, interview and document review, the facility failed to review and revise the resident care plan to include chemotherapy, breathing problems and oxygen use for 1 of 3 residents (R31) reviewed for care planning. Findings include: R31's quarterly minimum data set (MDS), dated 11/18/25, identified a diagnosis of congestive heart failure (CHF), rectal cancer, and atrial fibrillation. R31's care plan, dated 12/11/25, didn't contain a focus statement for coordination and care of R31's chemotherapy treatments, breathing problems or oxygen use. R31's provider orders, dated 1/12/26, didn't contain orders for oxygen use or the care and keeping of oxygen equipment. R31's Weights and Vitals Summary identified R31 was wearing oxygen via nasal cannula on dates when oxygen saturation levels were recorded starting on 10/29/25 through 1/15/26. R31's provider progress note dated 10/29/25, identified new orders related to CHF: repeat chest x-ray next week, monitor vital signs every shift for two weeks, monitor oxygen saturation every shift daily and as needed for two weeks, if 90 percent or less update provider, oxygen use during the day at two liters per minute (LPM) via nasal cannula while on chemotherapy, make sure oxygen is on at one LPM during the night. A provider progress note from 11/5/26, identified to continue to monitor oxygen use at two LPM via nasal cannula every shift, resident occasionally has nasal cannula not in nostrils. During an observation and interview on 1/12/26 at 3:35 p.m., R31 was observed wearing an oxygen cannula on his nose, the oxygen concentrator was set at one liter per minute (LPM) and R31 stated he wore oxygen daily. During an observation on 1/14/26 at 7:10 a.m., R31 was in bed sleeping, oxygen cannula was on his nose, and the concentrator was running. During an interview on 1/14/26 at 12:23 p.m., licensed practical nurse (LPN)-B stated R3 occasionally wore oxygen. During an interview on 1/14/26 at 2:36 p.m., the director of nursing (DON) stated continuous and as			20570			

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20570	Continued from page 5 needed (PRN) oxygen should have orders for them. The DON also stated she thought R31 had an order for oxygen because they were working on weaning him down and making sure his saturations stayed in an acceptable range. During an interview on 1/15/26 at 9:23 a.m., physical therapy assistant (PTA)-E confirmed he had been working with R31 since his admission, and R31 had been wearing oxygen when PTA-E was working with him, he thought R31 was currently on one LPM and checked his oxygen saturation levels while working with him. During an observation on 1/15/26 at 9:33 a.m., R31 was wearing oxygen via nasal cannula connected to an oxygen concentrator. During an interview on 1/15/26 at 10:28 a.m., LPN-A who was the clinical manager for R31, stated she would want orders in place if the resident was using oxygen. LPN-A confirmed R31's medical record didn't contain orders for oxygen. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are being revised and appropriate. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20570				
20860	Adequate and Proper Nursing Care; Hands-Feet CFR(s): MN Rule 4658.0520 Subp. 2 F. Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident who was unable to perform their own activities of daily living (ADL)s		20860	Corrected		02/13/2026	

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20860	Continued from page 6 received nail care for 1 of 3 residents (R44) reviewed for ADLs. Findings include: R44's quarterly minimum data set (MDS), dated 1/8/26, identified significant cognitive impairment and a diagnosis of late-onset Alzheimer's dementia. The MDS further indicated R44 was dependent in all ADLs. R44's care plan, dated 8/6/25, identified a focus statement for assistance with ADLs related to dementia, osteoarthritis, weakness and falls. Interventions included an assist of one with all ADL tasks including nail care, specifically to trim fingernails and toenails as needed on shower days. The care plan didn't include podiatry care for her toenails, nor did it address behavior or resistance to having nails trimmed. R44's provider orders, dated 8/6/25, identified an order to check fingernails and toenails once a week and provide nail care every Wednesday. Document in nursing note of any behaviors or refusals. R44's electronic medical record (EMR) didn't contain a progress note related to bathing, nail care or refusals of nail care on Wednesday 1/7/26. An assessment, Weekly Skin Inspection dated 1/7/26, identified R44 had a bath or shower and had her finger and toenails trimmed. During an observation and interview on 1/13/26 at 1:39 p.m., family member (FM)-D stated he was having issues with R44's nails not being taken care of, and unbeknownst to him was removed from the podiatry list so her nails didn't get taken care of. FM-D stated he had looked at R44's feet in the first place because she was complaining of foot pain, and he found the great toes each had about one inch overhang from the end of the toe. FM-D also stated he had told the nursing home in writing to put her back on the podiatry list and he had talked to the administrator about it. At 1:49 p.m., FM-D opened R44's hands, as her fingers were pulled in close to her palm, and remarked her fingernails were at least one-quarter inch long, there was brown matter under some of the nails, other nails appeared to be stained. FM-D stated he didn't like to see them like this and thought they needed a trim. During an interview on 1/13/26 at 3:28 p.m., nursing assistant (NA)-E stated they would be responsible for trimming resident nails for non-diabetics only, the diabetics were done by the nurse.		20860				

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20860	Continued from page 7 During an interview on 1/13/26 at 3:31 p.m., licensed practical nurse (LPN)-C stated R44's toenails were too thick for them to cut, but they could do her fingernails. During an observation and interview on 1/13/26 at 3:35 p.m., LPN-A, who was the clinical nurse manager for R44, stated R44 screamed bloody murder when they tried to trim her nails, and her family was aware of that. LPN-A stated she would expect nail care was done if it was documented as done. LPN-A looked at R44's fingernails and stated they were long and dirty as well. LPN-A stated she would have expected a nursing note and a notice to herself if R44 were refusing. During an interview on 1/13/26 at 3:58 p.m., the director of nursing (DON) stated she expected resident nails to be trim and clean. The DON explained she would have expected the nurse to have made a note if a resident were refusing care. Activities of Daily Living (ADL)s and Maintain Abilities Policy dated 3/31/23, identified a resident who was unable to carry out ADLs would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure proper care for residents who are dependent with ADLs. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20860				
20875	Adequate and Proper Nursing Care; Monitor TPR CFR(s): MN Rule 4658.0520 Subp. 2 I Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly.		20875	Corrected		02/13/2026	

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20875	Continued from page 8 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure orders were in place for a resident receiving oxygen for 1 of 7 residents (R31). In addition, the facility failed to assess and treat lower extremity edema for 1 of 7 residents (R23) reviewed for quality of care. Findings include: R31: R31’s quarterly minimum data set (MDS), dated 11/18/25, identified a diagnosis of congestive heart failure (CHF), rectal cancer, and atrial fibrillation. R31’s care plan, dated 12/11/25, didn’t contain a focus statement for breathing or oxygen use. R31’s provider orders, dated 1/12/26, didn’t contain orders for oxygen use or the care and keeping of oxygen equipment. R31’s Weights and Vitals Summary identified R31 was wearing oxygen via nasal cannula on dates when oxygen saturation levels were recorded starting on 10/29/25 through 1/15/26. During an observation and interview on 1/12/26 at 3:35 p.m., R31 was observed wearing an oxygen cannula on his nose, the oxygen concentrator was set at one liter per minute (LPM) and R31 stated he wore oxygen daily. During an observation on 1/14/26 at 7:10 a.m., R31 was in bed sleeping, oxygen cannula was on his nose, and the concentrator was running. During an interview on 1/14/26 at 12:23 p.m., licensed practical nurse (LPN)-B stated R3 occasionally wore oxygen. During an interview on 1/14/26 at 2:36 p.m., the director of nursing (DON) stated continuous and as needed (PRN) oxygen should have orders for them. The DON also stated she thought R31 had an order for oxygen because they were working on weaning him down and making sure his saturations stayed in an acceptable range. During an interview on 1/15/26 at 9:23 a.m., physical therapy assistant (PTA)-E confirmed he had been working with R31 since his admission, and R31 had been wearing oxygen when PTA-E was working with him, he thought R31		20875				

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20875	Continued from page 9 was currently on one LPM and checked his oxygen saturation levels while working with him. During an observation on 1/15/26 at 9:33 a.m., R31 was wearing oxygen via nasal cannula connected to an oxygen concentrator. During an interview on 1/15/26 at 10:28 a.m., LPN-A who was the clinical manager for R31, stated she would want orders in place if the resident was using oxygen. LPN-A confirmed R31's medical record didn't contain orders for oxygen. R23:R23's admit Minimum Data Set (MDS) dated 11/23/25, indicated R23 was moderately cognitively impaired with diagnoses of venous insufficiency, acute respiratory failure, and ischemic cardiomyopathy. R23's undated facility provided Care Plan included focus area: Alteration in skin integrity with interventions: monitor skin during cares, weekly skin inspection by nurse, tubi grips on in a.m. and off in h.s. [bedtime]. R23's Order Summary Report dated as of 1/15/2026, included the following orders: -Tubi grips [material designed to provide compression and reduce swelling] on in a.m., off at H.S. every morning and at bedtime related to acute combined systolic and diastolic congestive heart failure. -Weekly skin inspection by licensed nurse. Complete MHM Weekly Skin In section in PCC every day shift every Thursday. -Orders did not include treatments or lotions for legs. R23's Treatment Administration Record (TAR) for the month of January 2026, had documented entries between 1/1/26 and 1/14/26, were signed off to indicate R23's tubi grips had been put on in the a.m. and removed at bedtime. R23's ordered Weekly Skin Inspection were documented as follows in the electronic medical record (EMR): -11/13/25: "Res skin is dry and intact -11/28/25: did not see skin but NA had her dressed and said there was no issues. edema lower legs			20875			

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20875	Continued from page 10 -12/10/25: BLE edema, no weeping noted from legs, scabs. No other skin issues noted -12/18/25: Edema bilateral lower extremities which are reddened but not weeping at this time. Dry scaly skin on legs. No other skin issues noted. -12/25/25 Edema bilateral lower extremities which are reddened but not weeping at this time. Dry scaly skin on legs. 12/31/25 entry: No new skin issues. Skin is dry warm and intact -1/8/26 no new skin issues skin is dry warm and intact During an interview on 1/12/2026 at 5:23 p.m., R23 was wearing knee high socks and was seated in a recliner with legs elevated. R23 stated they had bad edema in their legs and indicated their family member (FM-A) was the one who took care of their legs. Their legs had been really big and leaking fluid before, but now the fluid was way down and their legs hurt less. R23 stated they didn't really have any treatments for their legs other than a water pill. During an interview on 1/12/26 at 6:00 p.m., both R23 and FM-A were present. R23 stated FM-A cared for their legs not the nurses. FM-A, was not sure what the nurses did, but confirmed they did care for R23's legs during daily visits. FM-A stated R23's legs still had dryness and edema, and scabs (pointed to several scabs on R23's left leg -skin on leg was dry with flakes of skin) but overall R23's legs were much improved. R23 stated she liked to wear their white socks because they were absorbent and comfortable. FM-A stated they had bought the socks for R23 and indicated they were just cotton, not compression socks. During an observation on 1/13/26 at 9:42 a.m., R23 was seated with white knee-high socks on. During an interview on 1/13/26 at 2:15 p.m., R23 was seated with legs elevated wearing white knee-high socks. R23 stated they had kept their socks on from yesterday, nobody had offered to put tubi grip sock for them this a.m. R23 stated they had worn compression tubi things before but could not recall when they had last worn them. No tubi grips were visible in R23's room or bathroom. During an observation on 1/13/26 at 4:14 p.m., R23 was seated in recliner with the same knee-high socks on.			20875			

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20875	Continued from page 11 During an observation on 1/14/26 at 7:16 a.m., R23 was seated in recliner, feet up, wearing the same knee-high socks. During an observation on 1/14/26 at 8:06 a.m., R23 remained in room with same knee-high socks on. During an observation on 1/14/26 at 11:58 a.m., R23 was being wheeled down the hall wearing the same white knee-high socks. R23 stated they were off to an appointment. During an interview on 1/14/26 at 3:13 p.m., licensed practical nurse (LPN-B) explained when they initialed something in the TAR it meant the task or treatment had been completed. LPN-B stated they had signed off on R23's tubi grips because they thought that R23 had been wearing them, but now they guessed they had not been on. LPN-B stated it was important for R23 to wear tubi grips because it helped prevent deep vein thrombosis (blood clots). During an interview on 1/14/26 at 3:15 p.m., the director of nursing (DON) stated when a task was signed off in the TAR it meant that task was completed. If a task was refused or not completed, they expected charting would reflect that. During an observation on 1/15/2026 at 9:45 a.m., R23 was seated in their recliner wearing their white knee-high socks. NA-D responded to R23's call-light and assisted R23 to the bathroom. During an after-care interview NA-D stated R23 did not wear tubi grips or anything like that. During an interview on 1/15/26 at 9:55 a.m., R23 was wearing white knee-high socks and stated staff had not offered to put any tubi compression things on them that morning. R23 stated their legs were more swollen today because of their appointment yesterday but overall, they felt their legs were much better. R23 indicated the staff didn't do any treatments to their legs, it was FM-A who had been washing and putting some kind of cream on their legs each day when they visited. During an interview on 1/15/26 at 11:44 a.m., clinical manager LPN-A opened R23's chart and stated R23 was not		20875				

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20875	Continued from page 12 being tracked in wound care because R23 did not have any active wound treatments. Instead R23's leg issues were being tracked in the weekly skin assessments. LPN-A reviewed documented skin assessments and stated they would expect skin assessments to reflect skin changes like new scabs and ideally old scabs and/or other ongoing skin issues. Details were important to determine improvement or worsening skin status. Although R23 did not have orders for lotion application to dry skin, it was expected that NAs would identify and apply lotion to dry skin as part of their routine care of residents. LPN-A confirmed R23 had an order for tubi grips and confirmed charting showed that R23 had been wearing tubi grips each day in January as ordered. It was important for R23 to wear the tubi grips because of the fluid retention R23 had in their lower legs. LPN-A indicated they were not aware R23 had not been wearing their tubi grips and stated they expected staff to document a task as not done if it was not done and communicate to them if it was ongoing so it could be addressed. During an interview on 1/15/26 at 12:05 p.m., the DON stated they expected skin inspection documentation to include descriptive findings of old and healing wounds as well as any new edema, weeping, scabs, or any other area of concern so the information could be used to implement or change treatments accordingly. When tubi grips are ordered, clinical managers should make sure the tubi grips are in the room and being applied as part of their resident monitoring oversight. Nurses are also responsible to ensure TAR orders are followed and should note if a resident is or is not wearing their tubi grips when they go into the resident's rooms and then document accordingly. The facility policy Skin Assessment & Wound Management dated 2/2025, included direction for daily skin inspection with cares, weekly skin inspection by licensed staff, implementation of appropriate preventive measures and referrals, notification and or update to provider, nurse, and family for new or ongoing skin issues as needed, care plan updating as needed, and to provide care and treatments as ordered. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures regarding oxygen care and edema care. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.			20875			

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20875	Continued from page 13		20875				
21385	The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. Infection Control; Staff assistance CFR(s): MN Rule 4658.0800 Subp. 3 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to perform appropriate hand hygiene while doing a brief change. The facility also failed to utilize appropriate personal protective equipment (PPE) for a resident in enhanced barrier precautions. This affected 2 of 5 resident (R54, R6) reviewed for infection control. Findings include: R6: R6's significant change Minimum Data Set (MDS) dated 12/13/25, identified he had diagnoses which included chronic obstructive pulmonary disease (a progressive lung condition that blocks airflow, making it hard to breath), right foot drop, spinal stenosis lumbar region with neurogenic claudication (nerve compression in the lower back from a narrowed spinal canal, causing symptoms like leg pain, cramping, numbness, or weakness that worsen with standing/walking), heart failure (the heart can't pump enough oxygen-rich blood to meet the body's needs), hypertension, and opioid dependence. In addition, R6's MDS identified he was cognitively intact and was dependent on staff for assistance with activities of daily living (ADLs). R6's MDS identified he was frequently incontinent of bowel. R6's care plan dated 12/9/25, identified R6 was on enhanced barrier precautions related to wounds and foley catheter. Interventions included to don and doff personal protective equipment when providing high contact cares. R6's Active Orders as of 1/15/26, identified he had orders for enhanced barrier precautions while providing		21385	Corrected	02/13/2026		

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21385	Continued from page 14 wound cares and other high contact care activities dated 12/9/25. During an observation on 1/13/26 at 1:25 p.m., nursing assistant (NA)-F entered R6's room, with a non-powered manual sit-to-stand transfer aid (NA-F was not wearing an isolation gown). NA-F closed the curtains, lowered the bed, prepared the bed with a lift sheet, put on gloves put did not put on an isolation gown and positioned R6 to use the transfer aid. After assisting R6 into the bed, NA-F gave R6 the call light, removed gloves, performed hand hygiene and took the transfer aid out of the room. NA-G and NA-F entered the room, both donned gloves, no isolation gowns and proceeded to complete a brief change (incontinent of stool). NA-F called for a nurse to check skin and to complete dressing changes. The director of nursing (DON) entered the room, she had gowned and gloved prior to entering the room. The DON performed the dressing changes, doffed the gown and gloves in the room, washed her hands with soap and water and exited the room. NA-F had removed her gloves after the brief change and washed her hands. NA-F put new gloves on and emptied R6's foley catheter. NA-F removed her gloves and performed hand hygiene before exiting the room. During an interview on 1/13/26 at 1:57 p.m., the DON verified the NAs should have been wearing isolation gowns when they were completing personal cares for R6 related to his foley catheter and wounds. Enhanced Barrier Precautions dated 4/1/24, identified "It is the practice of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms." The policy identified staff would wear gowns and gloves during high-contact resident care activities for residents known to be colonized or infected with a multi-drug-resistant organism (MDRO) as well those at increased risk of MDRO acquisition. Examples given were those residents with wounds or indwelling medical devices. High-contact resident cares included transferring, providing hygiene and changing briefs.R54: R54's quarterly Minimum Data Set (MDS) dated 10/10/25, indicated severe cognitive impairment, incontinence of bowel and bladder, and maximal assist to dependent for toileting, hygiene and cares. Diagnoses included non-traumatic brain dysfunction and dementia. During observation on 1/14/26 at 8:38 a.m., nurse assistant (NA)-B entered R54's room to change clothes, do a brief change and get up in chair. NA-B gathered		21385				

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21385	Continued from page 15 all needed equipment and placed on the bedside table. Hands were washed and clean gloves were placed on hands. The dirty gown was pulled down to the chest level, and the upper body was washed across the shoulders, neck and upper torso. The dirty gown was then completely removed from the resident, and a clean shirt was placed on the resident. Hands were not washed, and gloves were not changed at any time when going from dirty to clean. NA-B then gathered pants and placed them on the resident, pulling just up to the knees, still wearing the same dirty gloves. The brief was removed and peri care performed. Ointment was applied to the buttocks after cleaning. A clean brief was placed under the resident. NA-B removed the right-handed glove and proceeded to complete the brief change, touching the brief and peri area with the ungloved right hand several times. NA-A also came in contact with the dirty linens on the bed with the ungloved right hand. The Glove on the left hand was then removed. Without gloving, NA-B rolled R54 side to side, pulling the pants up the rest of the way, and removed all of the dirty linens under R54 with ungloved hands. New gloves were then put on without washing hands, the lift sling was placed under R54 and R54 was transferred from the bed to the chair. R54 was then taken to the hallway and setup for breakfast. Gloves were removed and hand sanitizer was used at that time. During an interview on 1/14/26 at 10:03 a.m., nurse assistant (NA)-B stated hands should be washed and new gloves put on when going from the dirty part of cares and start of clean part of cares. Gloves should never be removed and cares performed with ungloved hands. NA-B acknowledge she did not change gloves during cares and removed a glove and completed a brief change with an ungloved hand. During an interview on 1/15/26 at 10:03 a.m., the infection preventionist/director of nursing (IP) stated gloves needed to be changed and hands washed anytime they were going from dirty to clean when providing peri care. Example given was when the staff finished brief removal and cleaning of the peri area, hands would need to be washed, and gloves changed before placing the new clean brief on the resident. Facility policy Handwashing Policy last revised 2/24, indicated proper hand-washing techniques would be used to protect the spread of infection. Hand washing would be completed after changing incontinent products or cleaning up after someone who has used the toilet. The policy lacked information about hand hygiene when doing cares and placing clean items on right away.SUGGESTED METHOD OF CORRECTION:			21385			

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21385	Continued from page 16 The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff use proper procedures when completing personal cares and when taking care of residents in enhanced barrier precautions. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21385			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 01/14/2026	
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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/14/2026. At the time of this survey, The Waterview Pine LLC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR		K0000			02/13/2026	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. The Waterview Pines is a one-story building constructed in 1967, that was determined to be of Type V(000) construction, because of the presence of combustible wood framing in the ceiling of the upper level. In 1984 a Type II(000) addition was added and in 1997 a Type II(111) addition was added. For the purposes of this inspection the building was inspected as a Type V(000), which meets the standard. The facility to include the original 1967 building and the two additions have a full basement. The facility is protected throughout by a complete fire sprinkler system. The facility also has smoke detection throughout the corridors and spaces open to the corridors. The facility has a capacity of 95 beds and had a census of 80 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:		K0000				
K0252 SS = D	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4		K0252	K0252 Number of Exits - Corridors Immediate Corrective Action: Sign posted "Dead end /corridor, no exit" /at the entrance of the storage area in the basement under the "A" wing. Corrective Action as it applies to others:		02/13/2026	

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K0252 SS = D	Continued from page 2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview it was revealed that the facility failed to provided proper means of egress from the basement storage area under the "A" wing, in accordance with the NFPA Life Safety Code 101 2012 edition section 19.2.5.5.2. This deficient practice could have an isolated impact on the residents within the facility.. Findings include: On 01/14/2026 at 12:34pm, it was revealed by observation that the storage area in the basement, under the "A" wing, only has one exit. This area is approximately 7, 290 square feet in size. Rooms over 2,500 square feet require two remote exits. An interview with the Maintenance Director and Faculty Administrator verified this deficient finding at the time of discovery	K0252	Continued from page 2 NFPA Life Safety Code 101 2012 education section 19.2.5.5.2 reviewed. Maintenance staff educated on every corridor shall provide access to not less than two approved exits in accordance with sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. Date of Compliance: 2/13/2026 Recurrence will be prevented by: 5 areas will be checked to ensure they have proper exits weekly x4 weeks then monthly x2. These results will be shared with the facility QAPI committee to increase, decrease, or discontinue audits. Corrections will be monitored by: Administrator or Designee	02/13/2026
K0324 SS = D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.	K0324	K0324 Cooking Facilities Immediate Corrective Action: Alignment mark posted on the ground in front of the stove. Corrective Action as it applies to others: Life Safety Code section 19.3.2.5, 19.3.2.5.1, 19.3.2.5.2, 9.2.5, NFPA 96 (2011 edition) Ventilation control and fire protection of commercial cooking operations, section 12.1.2.3 and 12.1.2.3.1 reviewed. Maintenance staff educated to provide an approved method of attachment and/or an alignment mark to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 01/14/2026	
NAME OF PROVIDER OR SUPPLIER The Waterview Pines LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8TH STREET SOUTH PO BOX 971, VIRGINIA, Minnesota, 55792			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0324 SS = D	Continued from page 3 Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to install the kitchen hood extinguishing system in accordance with NFPA 101 (2012 edition), The Life Safety Code, section 19.3.2.5, 19.3.2.5.1, 19.3.2.5.2*, 9.2.5, NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations, section 12.1.2.3 and 12.1.2.3.1. These deficient findings could an isolated impact on the residents within the facility. The findings include: On 01/14/2026 at 13:01pm, it was revealed that the wheeled, gas-fired stove and griddle located on the cooking line in the kitchen was not provided with an approved method of attachment and/or an alignment mark to ensure the appliances was returned to an approved design location after it had been moved for maintenance and cleaning. Both the attachment device and alignment mark are required for each gas operated and deep fat fryer cooking device. An interview with the Maintenance representative and the Facility Administrator verified these deficient findings at the time of discovery			K0324	Continued from page 3 the appliances was returned to an approved design location after it had been moved for maintenance and cleaning. Date of Compliance: 2/13/2026 Recurrence will be prevented by: Kitchen stove will be checked to ensure there are proper alignment markings weekly x4 weeks then monthly x2. These results will be shared with the facility QAPI committee to increase, decrease, or discontinue audits. Corrections will be monitored by: Administrator or Designee		
K0521 SS = F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: ased on observations, a review of available documentation review and staff interview, that the facility has failed to install the facility's heating and ventilation in accordance with the NFPA Life Safety			K0521	waiver requested.		02/18/2026

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K0521 SS = F	Continued from page 4 Code 101 2012 edition sections 19.5.2.1 and 9.2.1, and NFPA 90A (2012 edition), Standard for the Installation of Air-Conditioning and Ventilating Systems, section 4.3.12.1.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 19.4.1.1. This deficient condition could have a widespread impact on the residents within the facility Findings include: On 01/14/2026 at 11:21am, it was revealed by observation that Wings A and B have air supplies located in the corridors and the resident rooms have air exhausts located in the bathroom. This combination of air movement indicated that the facility is using these corridors as a return air plenums. An interview with the Maintenance Director and Faculty Administrator verified this deficient finding at the time of discovery		K0521				
K0741 SS = F Bldg. 01	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily		K0741	K0741 Smoking Regulations Immediate Corrective Action: Residents who smoke were educated on location of smoking area. Corrective Action as it applies to others: Life safety code section 19.7.4 reviewed. Residents who smoke were educated on designated smoking area. All staff education provided to ensure residents use the designated smoking area. Date of Compliance: 2/13/2026 Recurrence will be prevented by:		02/13/2026	

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K0741 SS = F Bldg. 01	Continued from page 5 available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to implement a staff smoking policy per NFPA 101 (2012 edition), Life Safety Code section 19.7.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 01/14/2026 at 11:21am, it was revealed by observation that the smoking was occurring by front entry way under roof overhang as evident by discarded cigarette butts. An interview with the Maintenance Director and Faculty Administrator verified this deficient finding at the time of discovery			K0741	Continued from page 5 5 residents will be evaluated to ensure the designated smoking area is being used weekly x4 weeks then monthly x2. These results will be shared with the facility QAPI committee to increase, decrease, or discontinue audits. Corrections will be monitored by: Administrator or Designee		