



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 13, 2026

Administrator
THE WATERVIEW SHORES LLC
402 - 13TH AVENUE
TWO HARBORS, MN 55616

RE: CCN:245471

Cycle Start Date: July 23, 2026

Dear Administrator:

On July 23, 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 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)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "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

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 23, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 23, 2027 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245471		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026			
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW SHORES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE , TWO HARBORS, Minnesota, 55616					
(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 7/20/26 to 7/23/26, 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			08/21/2026			
F0000	INITIAL COMMENTS On 7/20/26 to 7/23/26, a standard recertification survey (S#S5471039-0) was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.		F0000					08/21/2026	
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -		F0812						
				Staff education provided on Handwashing Policy, Handwashing Skill observed for all staff before next scheduled shift. Handwashing Policy reviewed and remained current.					

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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F0812 SS = E	Continued from page 1 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure dietary staff adhered to food safety practices during meal preparation. This had the potential to affect residents, guests, and staff receiving meals served from the kitchen. Findings include: During an observation on 7/21/26 at 9:19 a.m., cook (C)-A opened two packages of raw ground meat on a cutting board and placed the meat in a bowl wearing gloves. C-A removed the gloves which had visible meat juices on them and put on new gloves without washing their hands. C-A then went to the fridge, opening the fridge door with a gloved hand, and removed a carton of liquid eggs. C-A returned to the prep table, removed the cutting board containing meat juices, took it to the dishwasher, rinsed it, loaded it in the dishwasher, removed their gloves, and did not wash their hands. C-A removed spices from a cabinet, put on new gloves without handwashing, and returned to the prep table to add ingredients to the bowl containing ground meat. During an interview on 7/21/26 at 9:25 a.m., C-A confirmed they had not washed their hands when changing gloves while making meatloaf and stated they should wash their hands between glove changes. They stated handwashing was important to keep germs out of food.			F0812	Continued from page 1 Observed all culinary staff during food preparation to ensure proper handwashing was performed between each task while preparing meals per food safety requirements. Culinary staff are educated on Handwashing Policy, to ensure every time gloves are removed, they are washing hands before and after to follow food safety practices during meal preparation. Audits for hand washing in between glove changes and before and after glove use during meal preparation will be observed during one meal prep weekly x4 weeks, and monthly x2 months to ensure food safety practices are being followed. The results of the audit will be shared with the facility QAPI committee for the need to increase, decrease or discontinue the audits. Corrections will be monitored by Administrator or Designee		08/21/2026

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F0812 SS = E	Continued from page 2 During an interview on 7/21/26 at 10:56 a.m., culinary director (CD) stated they expect the cooks to wear gloves during food preparation, change gloves frequently between tasks, and wash hands in between glove changes. The CD indicated handwashing was important to reduce the risk of transferring bacteria to the new gloves. During an interview on 7/22/26 at 9:58 a.m., the infection preventionist (IP) stated it was important to wash hands when changing gloves to prevent the spread of infection. The IP expected all staff to perform hand hygiene when changing gloves. Handwashing policy dated 2/2024, instructed all employees to do proper hand washing before putting on gloves and after removing gloves. Food Preparation and Service policy revised 4/2019, instructed food preparation staff to adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness.			F0812			08/21/2026
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to change all tube feeding supplies			F0693	Order placed in PCC for floor nurse to change and date graduate daily which requires staff to sign off on to ensure completion. There are currently no other tube feeding residents in the facility to review for compliance. Enteral Tube Feeding via Syringe Policy reviewed and remains current. All licensed nurses educated on tube feeding supplies need to be changed daily. Recurrence will be prevented by: Audits for tube feeding supplies being changed daily will be completed weekly x4 weeks and then monthly x3. The results of the audit will be shared with the facility QAPI committee for the need to increase, decrease, or discontinue the audits. Corrections will be monitored by DON or Designee		08/21/2026

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F0693 SS = D	Continued from page 3 every 24-hours for 1 of 1 (R4) resident reviewed for tube feeding. Findings include: R4's quarterly Minimum Data Set (MDS) dated 6/25/26 indicated R4 had moderate cognitive impairment. Diagnoses included right sided stroke and dysphagia. The MDS also indicated R4 received tube feedings. R4's care plan undated, indicated a potential alteration in nutrition related to a stroke and no intake by mouth, which required enteral tube feeding. Interventions included enteral feeding and flushes as ordered. The care plan also indicated the syringe, feeding bag, and graduate needed to be changed every twenty-four (24) hours (hr). R4's provider orders undated, indicated the tube feeding syringe needed to be changed daily. During an observation on 7/20/26 at 12:04 p.m., R4's graduated cylinder, holding the tube feeding syringe, was observed on the bedside table with the date of 7/19/26 written on it. The syringe itself was not dated. During a second observation on 7/21/26 at 9:26 a.m., the graduated cylinder with the date of 7/19/26 was again seen on R4's bedside table with an undated syringe in it. During an interview on 7/21/26 at 12:14 p.m., licensed practical nurse (LPN)-A stated the graduate and the tube feeding syringe was to be changed weekly unless there was obvious dirtiness noted on either of them. If obviously dirty, then the graduate and/or syringe would be changed right away. LPN-A examined the graduate and confirmed the date written was 7/19/26. That is the last time any of the tube feeding had been changed that LPN-A was aware of. After the supplies were changed, everything would be documented in the treatment record. During an interview on 7/22/26 at 10:54a.m., the director of nursing/infection preventionist (DON/IP) stated staff were expected to follow the policy related to the changing all tube feeding supplies. The DON/IP reviewed the policy and stated all supplies would need to be changed every 24hrs. The tube feeding supplies needed to be changed every 24 hours because fluids were put in the graduate and the syringe. As the fluids sat in both, the risk of bacteria growth and risk of infection increased. Facility policy Enteral Tube Feeding via Syringe (Bolus) dated 3/24, indicated the staff needed to ensure the syringe had been labeled with the resident's name and the date and time. If the date and time was greater than 24hrs the staff needed to dispose of the supplies and get new.			F0693			08/21/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/22/2026. At the time of this survey, The Waterview Shores 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			K0000			08/21/2026

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.

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR 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. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur.3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.4. Identify who is responsible for the corrective actions and monitoring of compliance.5. The actual or proposed date for completion of the remedy. The Waterview Shores LLC is a 1-story building that was constructed in 1979 with a partial basement that was determined to be of Type II(111) Construction. In 1998 a one-story addition with no basement was constructed that was determined to be of Type II(111). In 2001 a kitchen addition was constructed and was determined to be of Type II(111). The facility has 3 separate smoke compartments, and in 2001, an assisted living building was added, that is properly 2-hour rated separated from the nursing home. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a capacity of 44 beds and had a census of 39 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			08/21/2026
K0225 SS = F Bldg. 01	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2.			K0225	Chain with clip fastened to wall and handrail at the top of stairway leading to basement. Stairway chain remains clipped across top of stairway to prevent traveling past the level of discharge during a building emergency evacuation.		07/27/2026

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K0225 SS = F Bldg. 01	Continued from page 2 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell arrangement and markings per NFPA 101 (2012 edition), Life Safety Code, section 7.7.3.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/22/2026, at 12:13pm, , it was revealed by observation that the facility failed to provide an approved means to prevent or dissuade occupants from traveling past the level of discharge during emergency building evacuation. An interview with the Maintenance Director and Facility Administrator verified this deficient finding at the time of discovery.			K0225	Continued from page 2 Chain latch will be audited to ensure it remains latched weekly x4, monthly x2 to ensure safety. The results of the audit will be shared with the facility QAPI committee for the need to increase, decrease or discontinue the audits. Corrections will be monitored by Administrator or Designee		07/27/2026
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/22/2026, at 10:42am, it was revealed by a review of available documentation that fire drills			K0712	Education to Maintenance Director on fire drill policy including shift start and stop times. Fire drills to be reviewed before drill is started to verify correct shift and time. Fire Drills will be audited monthly to ensure documentation is correct on time and shift of drill being performed. Audits will be completed monthly x4 to ensure compliance. The results of the audit will be shared with the facility QAPI committee for the need to increase, decrease or discontinue the audits. Corrections will be monitored by Administrator or Designee		08/17/2026

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K0712 SS = F Bldg. 01	Continued from page 3 were not completed. Fire drill document was marked as second shift but was conducted at 10:45pm which is third shift. Facility could not produce document that showed a third shift fire drill had been conducted for second shift, second quarter. An interview with the Maintenance Director and Facility Administrator verified this deficient finding at the time of discovery.			K0712			08/17/2026
K0324 SS = D Bldg. 01	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. 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 documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include:			K0324	Kitchen hood ventilation and fire suppression system inspection were completed on 7/28/26. Culinary and Maintenance Directors received education on ensuring semi-annual and annual inspections and ensure timely completion by the contractor. Semi-annual and annual kitchen hood ventilation inspections are set up in TELS and calendar reminders are set to contact the contractor one week before semi-annual date to confirm kitchen hood inspection. An audit will be conducted to verify inspections are set up in TELS and reminder is on calendar. Audit will be reviewed with the facility QAPI committee to verify compliance. Corrections will be monitored by Administrator or Designee		07/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245471		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 07/22/2026	
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW SHORES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE , TWO HARBORS, Minnesota, 55616			
(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 Bldg. 01	Continued from page 4 On 07/22/2026, at 11:25am, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for the semi-annual kitchen hood suppression system inspections for the last 12 months. Facility provided annual, but did not have documentation for the previous 6 month inspection. An interview with the Maintenance Director and Facility Administrator verified this deficient finding at the time of discovery.			K0324			07/28/2026
K0921 SS = D Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a policy for appliances not supped by the facility per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.1.2, 10.3.5.4, 10.3.6, 10,5.2.5, 10.5.6.1.1, 10.5.6.1.2, 10.5.6.1.3, 10.5.6.1.4, 10.5.6.2.1, 10.5.6.2.2. (1			K0921	PCREE training of qualified personnel was completed. Tagging of electrically powered medical equipment was completed. PCREE testing was documented on all electrically powered medical equipment. PCREE guidance was reviewed and remains current. Education was provided to Maintenance Director and Administrator on PCREE training, testing and documenting. Audit will be conducted 4x monthly to ensure PCREE testing and documentation is completed on current and any new electrically powered medical equipment. Audit results will be reviewed with facility QAPI committee to verify compliance. Corrections will be monitored by Administrator or Designee		09/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245471		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 07/22/2026	
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW SHORES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE , TWO HARBORS, Minnesota, 55616			
(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
K0921 SS = D Bldg. 01	Continued from page 5 - 3), 10.5.8.1, 10.5.8.1.1, 10.5.8.1.2, 10.5.8.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/22/2026, at 11:37am, it was revealed by a review of available documentation that the facility could not provide documentation for the testing of electrically powered medical equipment or provide documentation showing certifications and/or training for qualified personnel to conduct said testing for this facility. An interview with the Maintenance Director and Facility Administrator verified this deficient finding at the time of discovery.			K0921			09/02/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 23, 2026

Administrator
THE WATERVIEW SHORES LLC
402 - 13TH AVENUE
TWO HARBORS, MN 55616

RE: CCN: 245471
Cycle Start Date: July 23, 2026

Dear Administrator:

On September 11, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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