Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 10, 2025

Administrator
The Waterview Shores LLC
402 - 13TH AVENUE
TWO HARBORS, MN 55616

RE: CCN: 245471
Cycle Start Date: June 5, 2025

Dear Administrator:

On July 8, 2025, the Minnesota Department of Health 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,

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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Electronically delivered

September 10, 2025

Administrator
The Waterview Shores LLC
402 - 13TH AVENUE
TWO HARBORS, MN 55616

Re: Reinspection Results
Event ID: 89V312

Dear Administrator:

On July 8, 2025 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 June 5, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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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

Electronically delivered
June 20, 2025

Administrator
The Waterview Shores LLC
402 - 13th Avenue
Two Harbors, MN 55616

RE: CCN: 245471
Cycle Start Date: June 5, 2025

Dear Administrator:

On June 5, 2025, a survey was completed at your facility by the Minnesota Departments 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 September 5, 2025 (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 December 5, 2025 (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

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245471	A. BUILDING _____ B. WING _____	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW SHORES LLC	402 - 13TH AVENUE TWO HARBORS, MN 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
E 000	Initial Comments On 6/2/25-6/5/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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.	E 000		
F 000	INITIAL COMMENTS On 6/2/25-6/5/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was 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.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments.	F 641		7/3/25

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

Electronically Signed | 06/30/2025

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

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F 641	Continued From page 1 The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure Section N of the Minimum Data Set (MDS) was accurately coded for 1 of 3 residents (R7) reviewed for unnecessary medications. Findings include: R7's quarterly MDS dated 3/6/25, identified a diagnosis of diabetes mellitus. Section N, which	F 641	F641 Accuracy of Assessments Immediate Corrective Action:¿¿¿ R7’s Section N of the MDS was modified for accuracy.	

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F 641	Continued From page 2 covers medications received during the assessment period, identified R7 was given insulin injections two times during the look back period. R7's provider order, identified dulaglutide subcutaneous solution (a GLP-1 receptor agonist, which is not insulin) 0.5 milliliters (ml)/5 milligrams (mg) to be injected one time a week every Wednesday related to diabetes mellitus, and was not taking any inslun during the look back period During an interview on 6/4/25 at 12:56 p.m., licensed practical nurse (LPN)-A reviewed R7's medication list and confirmed R7 didn't take insulin. During an interview on 6/5/25 at 3:38 p.m., registered nurse (RN)-A, an MDS coordinator, stated section N was coded inaccurately for R7. RN-A stated accurately coding the MDS was important because it reflected the plan of care for the resident. A policy regarding MDS completion and accuracy was requested but not received.	F 641	Corrective Action as it applies to others:¿¿ All residents on GLP-1 medications were audited to ensure accurate coding on MDS Section N. Education was provided to MDS licensed nurses regarding need for accuracy of MDS's and following the RAI manual. Date of Compliance: 7/3/2025 Recurrence will be prevented by:¿¿ Audits of 5 residents on GLP-1 medications will be completed weekly x4, then monthly x2 months to ensure assessments are coded accurately. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by:¿ DON or designee¿	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		7/3/25

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F 689	Continued From page 3 §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 secure an oxygen tank in a resident room for 1 of 1 resident (R32) reviewed for accidents. Findings include: R32's quarterly Minimum Data Set (MDS) dated 5/14/25, identified R32 had diagnoses which included chronic obstructive pulmonary disease (COPD [a group of lung diseases that block airflow and make it difficult to breath]), depression and anxiety. In addition, R32 was cognitively intact and required substantial to maximum assistantance with activities of daily living. R32's undated Order Summary Report identified R32 had an order for oxygen two to four liters via nasal cannula. R32's care plan dated 2/13/25, identified R32 had an alteration in oxygen/gas exchange related to COPD. Interventions included to monitor oxygen saturations as ordered and as needed and to administer oxygen as ordered. During an observation on 6/2/25 at 1:58 p.m., R32 was seated in his wheel chair in his room	F 689	F689 Free of Accident Hazards/Supervision/Devices Immediate Corrective Action:¿¿¿ R32's free standing tank was placed in a stationary oxygen holder. Corrective Action as it applies to others:¿¿ All residents with oxygen tanks will be assessed to ensure there are no free-standing tanks in their rooms. Education will be provided to all licensed nurses, TMA's and NAR's regarding the need for oxygen tanks to be secured in a stationary oxygen holder or in an oxygen tank bag secured to the back of a wheelchair, and that oxygen tanks cannot be left free standing in a resident's room. Date of Compliance: 7/3/2025 Recurrence will be prevented by:¿¿	

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F 689	Continued From page 4 wearing oxygen via nasal cannula at one liter. During an observation on 6/3/25 at 11:14 a.m., in R32's room an oxygen tank was observed free standing near a stationary oxygen holder that contained five other oxygen tanks. The maintenance director (M)-A was present and verified oxygen tanks should always be secured in a holder for safety. M-A stated the tank if knocked over could turn into a missile and go through walls. During and interview on 6/3/25 at 11:22 a.m., the associate administrator verified oxygen tanks should always be secured and not free standing for safety. During an interview on 6/5/25 at 10:21 a.m., licensed practical nurse (LPN) verified staff received oxygen train as part of hazard training. During an interview on 6/5/25 at 12:58 p.m., the director of nursing (DON) verified oxygen tanks should never be left free standing. The DON verified the danger was the oxygen tank could tip over and go through a wall. A policy on oxygen storage was requested but not provided.	F 689	Audits of 5 residents with oxygen tanks will be completed weekly x4, then monthly x2 months to ensure there are no free standing tanks in resident rooms. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by:¿ DON or designee¿	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		7/3/25

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F 695	Continued From page 5 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the water chamber of a bipap machine was emptied and dried between uses for 1 of 3 residents (R143) reviewed for respiratory care. Findings include: R143's admission MDS dated 5/28/25, identified intact cognition and diagnoses of acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), acute bronchospasms, and sleep apnea. R143's care plan dated 5/23/25 didn't address the care of oxygen and bipap equipment. R143's provider orders dated 5/21/25 identified the following: -Bipap machine on at nighttime, two liters oxygen while sleeping to keep saturations at or above 92 percent. -Change nebulizer tubing and mask weekly on Saturday -Change water on bipap daily. Empty and dry out chamber and fill bipap water chamber with distilled water to the fill line at bedtime. During an interview on 6/2/25 at 4:04 p.m., R143 stated she used her oxygen and bipap daily. The bipap machine is on the table next to her med, there is moisture visible in the water chamber, with the face mask attached to the hose and	F 695	F695 Respiratory/Tracheostomy Care and Suctioning Immediate Corrective Action:¿¿¿ R143's BIPAP machine was emptied and dried. Corrective Action as it applies to others:¿¿ All residents with BIPAP's will be assessed to ensure each resident has orders to empty and dry the chamber of the BIPAP daily. Education will be provided to all licensed nurses and TMA's regarding the need to empty and dry the BIPAP chamber daily. Date of Compliance: 7/3/2025 Recurrence will be prevented by:¿¿	

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F 695	Continued From page 6 coiled on top of the dresser. During an observation on 6/3/25 at 10:10 a.m., R143 was not in her room. The bipap machine is on bedside table with water visible in the chamber. During an observation and interview on 6/5/25 at 12:51 p.m., R143's bipap machine is beside her bed with the water chamber partly full of water, the mask is attached to the tubing. R143 stated the staff filled the water chamber on the bipap machine for her, and so far no one had come to empty and rinse out the water chamber. During an interview on 6/5/25 at 1:05 p.m., LPN-A stated bipap and cpap machines should have the water emptied and chambers dried, and the face mask wiped down, every day. LPN-A added the filters were changed on Saturdays, and that R143 had been refusing her bipap at times. During an interview on 6/5/25 at 1:48 p.m., the DON stated she would expect the water chamber to be emptied and refilled daily, because it was important to help prevent possible infections. A policy was requested but not received.	F 695	Audits of 5 residents with BIPAP's will be completed weekly x4, then monthly x2 months their BIPAP's are being emptied and dried. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by:¿ DON or designee	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §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	F 812		7/3/25

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F 812	Continued From page 7 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 food temperatures were monitored prior to and during meal service to prevent risk of food-borne illness. This had the potential to affect all 42 residents residing at the facility. Findings include: During observation on 6/3/25 at 8:40 a.m., residents were being served breakfast. Breakfast consisted of scrambled eggs, sausage, and cinnamon rolls. Eggs and sausage were in aluminum foil inside of crock pots on both units of the facility. Crock pots were set to the "warm" setting. Staff served residents individually and plated their requested food from the crock pots. Staff did not check the temperature of the food during the breakfast service. During observation on 6/4/25 at 7:12 a.m., residents were being served breakfast. Breakfast consisted of biscuits and gravy. Gravy was in the crock pots on east and west units of the facility. Crock pots set to the "warm" setting.	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary Immediate Corrective Action:¿ Food temperatures during breakfast service were monitored prior and during meal service.¿¿ Corrective Action as it applies to others:¿¿ Food temperatures will be checked prior to breakfast meal service and then hourly until the meal service is completed. Education will be provided to all culinary staff regarding the need to check food temperatures hourly during the breakfast	

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F 812	Continued From page 8 During observation on 6/4/25 at 7:58 a.m., both crock pots were still on and set to "warm" setting. During observation on 6/4/25 at 8:31 a.m., both crock pots were still on and set to "warm" setting. During observation on 6/4/25 at 9:29 a.m., both crock pots were still on and set to "warm" setting. During observation on 6/4/25 at 10:15 a.m., both crock pots were still on and set to "warm" setting. During observation on 6/4/25 at 10:31 a.m., east unit crock pot was off and empty. West unit crock pot was on and set to "warm" setting. During interview on 6/4/25 at 11:36 a.m., dietary aide (DA)-A stated dietary staff were responsible for bringing out breakfast in the morning. DA-A further stated they did not check breakfast food temperatures and was unsure of who did. During interview on 6/4/25 at 11:45 a.m., corporate dietary manager (CDM) stated concerns with using crock pots for food service. CDM explained temperature control was difficult with the crock pots. CDM further stated temperature control was important to food service in order to prevent food-borne illness. During interview on 6/5/25 at 9:11 a.m., nursing assistant (NA)-A stated dietary staff bring out breakfast and put into crock pots. NA-A further stated they never had to temp breakfast. The breakfast temperature logs were requested but not provided. Per email with administrator on 6/5/25 at 10:23 a.m., "Thank you for bringing the	F 812	meal service. The Food Preparation and Service Policy was reviewed and remains current. Date of Compliance: 7/3/2025 Recurrence will be prevented by:¿¿ Audits of breakfast meal service will be completed weekly x4, then monthly x2 months to ensure breakfast meal service is having food temperatures checked prior to meal service and hourly through the completion of meal service. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by:¿ Administrator or Designee	

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F 812	Continued From page 9 breakfast temps to our attention. We have food log temps, however it appears that breakfast was not a meal included with this." The facility Food Preparation and Service policy revised April 2019, indicated "proper hot and cold temperatures are maintained during food service.' Policy also instructed 'the temperatures of foods held in steam tables are monitored throughout the meal by food and nutrition services staff."	F 812		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing	F 851		7/3/25

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F 851	Continued From page 10 information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure staffing data was correctly submitted, for 1 of 4 quarters(quarter 3) reviewed, to the Centers for Medicare and Medicaid Services (CMS) according to specifications	F 851	F851 Payroll Based Journal Immediate Corrective Action: PBJ	

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F 851	Continued From page 11 established by CMS. Findings include: The Payroll Based Journal Report (PBJ) Casper Report 1705D for quarter 3 2024 (April 1 - June 30), identified the metric for failure to have licensed nursing coverage 24 hours per day and low weekend staffing were triggered. The PBJ report indicated the facility did not have licensed nursing coverage for the following dates: -4/27/24 -4/28/24 -5/11/24 -5/12/24 -5/18/24 -6/1/24 -6/22/24 -6/23/24 -6/29/24 Review of timecards from the listed dates showed the facility had licensed nursing staff coverage for 24 hours on each date. During joint interview on 6/5/25 at 12:44 p.m., administrator, associate administrator (AA), and corporate nurse (CN) stated being unaware of any problem with the submission of staffing data. Administrator, AA, and CN could not state why the PBJ report indicated a lack of licensed nursing coverage. AA stated the discrepancy might have been related to using agency staff, but did not actually know if that was the problem. A policy on PBJ was not provided.	F 851	submissions and reporting process was modified to ensure all reportable hours, including agency hours, are tracked in one system and accurately reported. Corrective Action as it applies to others:¿¿ PBJ submissions and reporting process was modified to ensure all reportable hours, including agency hours, are tracked in one system and accurately reported. Date of Compliance: 7/3/2025 Recurrence will be prevented by:¿¿ PBJ submissions and reporting process was modified to ensure all reportable hours, including agency hours, are tracked in one system and accurately reported. A second level review and approval process was implemented. Results of review and approval process will be reviewed at facility QAPI committee for input on the need to review subsequent submissions. Corrections will be monitored by:¿ Administrator or designee¿	
F 880 SS=F	Infection Prevention & Control	F 880		7/3/25

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F 880	Continued From page 12 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control 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	F 880		

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F 880	Continued From page 13 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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure alcohol-based hand sanitizer was in use in the hand hygiene dispensers throughout the facility. In addition, the facility failed to ensure shared equipment was disinfected between residents for 1 of 2 residents (R9) observed to use a lift; failed to ensure staff completed appropriate hand hygiene and glove use for 2 of 4 residents (R1, R22) observed during cares; failed to ensure the overnight urine	F 880	F880 Infection Prevention & Control Immediate Corrective Action:¿¿¿ All non-alcohol-based hand sanitizers were removed and disposed of and replaced with alcohol-based hand sanitizers.	

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F 880	Continued From page 14 collection bag was cleaned prior to storage for 1 of 1 residents (R10) reviewed for catheter care. Findings include: Facility Hand Sanitizer During an observation on 6/3/25 at 3:40 p.m., the hand sanitizer in a free standing black eco lab stand felt like water and did not have an alcohol odor. A staff member opened the hand sanitizer compartment and the container was labeled as benzalkonium. The associate administrator and the director of nursing (DON) were present and both stated they were not aware the product was not an alcohol based product. The associate administrator went to see what kind of product was in resident rooms and confirmed it was the same eco lab product in the resident room with the benzalkonium product. This had the potential to affect all residents residing in the facility, as all resdient rooms had the eco lab product in the wall mounted dispensers. During an interview on 6/4/25 at 8:25 a.m., the nurse consultant (NC)-E verified the benzalkonium product was five to nine percent alcohol and hand sanitizer products needed to be at least 65% alcohol based. The label on the hand sanitizer product identified it as Ecolab DigiSan with the active ingredient as benzalkonium chloride 0.1%. The Centers for Disease Control (CDC) Handsanitizer guidelines and recommendations dated 3/12/24, identified the following: "Hand Sanitizer Guidelines and	F 880	The shared equipment was disinfected. Re-education provided to licensed nurses, TMA's and NAR's regarding appropriate hand hygiene and glove use. Competencies completed with all licensed nurses, TMA's and NAR's for glove use and hand hygiene during perineal care. R10's overnight collection bag was replaced with a new bag. Corrective Action as it applies to others:¿¿ All hand sanitizer stations were replaced with alcohol-based hand sanitizers. Disinfecting wipes were added to all mechanical lift bags. Date of Compliance: 7/3/2025 Recurrence will be prevented by:¿¿Audits	

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F 880	Continued From page 15 Recommendations Key the following points: - Washing hands with soap and water is the best way to get rid of germs in most situations. - If soap and water are unavailable, use a hand sanitizer with at least 60% alcohol to clean your hands. - You can tell if the sanitizer contains at least 60% alcohol by checking the product label." The facility policy Hand Washing dated 2/2024, identified hands should be washed "before eating food", and "Alcohol-Based Hand Sanitizers (ABHS) - ABHS should not be used as a replacement for proper hand washing when hands are visibly soiled. If, however, hands are not visibly soiled, or soap and water are not available, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used to quickly reduce the number of germs on hands." The undated Ecolab manufacurers indications for benzalkonium chloride 0.1%. identified that "Food code-compliant hand sanitizer gel that reduces the level of bacteria on hands for use between soap and water hand washing. This formula is more than 99.5% effective in in-vitro testing against a broad range of foodborne illness-causing bacteria." and is appropriate for kitchen use. Equipment Disinfection R9's quarterly Minimum Data Set (MDS) dated 3/17/25, identified R9 had diagnoses which included heart failure, urinary retention, diabetes mellitus, , and dementia. In addition, R9 had moderate cognitive impairment and was dependent on staff for activities of daily living	F 880	of 5 hand sanitizer stations will be completed weekly x4, then monthly x2 months to ensure alcohol-based hand sanitizer is present. Audits of 3 mechanical lifts will be completed weekly x4, then monthly x2 to ensure disinfectant wipes are present with the lift and staff are disinfecting the lift in between shared use. Audits of 5 staff will be completed weekly x4, then monthly x2 to ensure proper hand hygiene and glove use was performed during cares. Audits of 3 resident's with urinary drainage bags will be completed weekly x4, then monthly x2 to ensure staff are properly cleaning and storing the drainage bag when not in use. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by:¿ DON or designee¿	

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F 880	Continued From page 16 including bed to wheel chair transfers. During an observation on 6/3/25 at 2:21 p.m., NA-C was observed bringing R9 into her room, NA-C exited the room. A sign was posted on the outside door which identified the resident was on enhanced barrier precautions. On 6/3/25 at 2:26 p.m., NA-C brought a mechanical lift into R9's room, came out and put on an isolation gown and put on gloves and went back into the room closing the door. On 6/3/25 at 2:49 p.m., NA-C brought the mechanical lift out of R9's room and parked in against the wall. There were not any cleaning wipes in the pocket on the mechanical lift. On 6/3/25 at 2:56 p.m., NA-C stated nights cleans the mechanical lifts. NA-C stated she wiped the machine down after using it with the skin care wipes that were in the room. NA-C verified R9 was on enhanced barrier precautions. On 6/5/25 at 12:59 p.m., the DON stated she would expect staff to clean lift equipment after use, she verified it was not acceptable to disinfect the equipment with the personal care wipes used for resident cares. A policy on equipment disinfection was requested but not provided. Hand Hygeine, Glove Use R1 R1's quarterly MDS dated 4/2/25, identified R1 had diagnoses which included broken left hip	F 880		

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F 880	Continued From page 17 prosthesis sequela, open left hip joint, morbid obesity, acquired absence of left hip joint, depression, anxiety, and schizophrenia. R1's had mild cognitive impairment, was dependent on staff for activities of daily living, had no rejections of care, and had a surgical wound. R1's care plan was requested but not provided. On 6/4/25 at 10:22 a.m., NA-D and NA-G put on isolation gowns and gloves and entered R1's room after knocking. NA-D and NA-G rolled R1 to his right side and NA-G cleaned stool from the buttocks using disposable wipes. NA-F then applied protective ointment to R1's buttocks, without removing the soiled gloves. R1 had more stool which was cleaned again by NA-G who then placed a new brief and pad and took the protective ointment tube and reapplied the ointment, without changing gloves or providing hand hygiene, R1 was rolled to his back. NA-D then took the protective ointment from NA-G and applied the ointment to R1's right hip. Both NA's removed their gloves, isolation gowns, performed hand hygiene with hand sanitizer and exited the room. During an interview on 6/4/25 at 10:43 a.m., NA-G verified they should have changed gloves and sanitize their hands after cleaning a resident who had a bowel movement. NA-G verified they did not do this during cares. During an interview on 6/5/25 at 12:59 p.m., the DON stated she would expect staff to change their gloves and wash their hands after cleaning a resident who'd had a bowel movement. R22:	F 880		

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F 880	Continued From page 18 R22's annual MDS dated 4/2/25, identified R22 had severe cognitive impairment and diagnoses of dementia, palliative care, limitation of activities due to disability, and low back pain. R22 needed extensive assist with bed mobility, was non-ambulatory, dependent for transfers, frequently incontinent of bowel and occasionally incontinent of urine. R22's care plan was not provided. On 6/3/25 at 11:45 a.m., NA-D and NA-C were assisting R22 with incontinence, after removing her soiled brief and having her use the commode. Both NAs were wearing gloves. NA-C used a cloth to provide peri care, first to the front and then to the back. NA-D assisted to hold R22 on her right side while NA-C tucked a clean brief underneath R22 while wearing the same gloves she provided peri care with. Both NAs worked together to get R22's pants on, and the sling for the lift centered underneath her. NA-C positioned R22's wheelchair underneath her while NA-D operated the lift controls, and once seated both NAs removed the loops from the sling. NA-C picked up and moved the commode out of the way, opened the door to the hall, grabbed a hold of the sling lift, all while wearing the same gloves, and brought the lift out into hall. NA-C left the lift along the side of the hall, walked across the hall to the kitchenette, removed her gloves and threw them in a trash can, then turned and grabbed a coffee cup off a table and walked toward the dining room. During interview on 6/3/25, at 12:15 p.m. NA-C stated she would normally wash her hands after removing gloves, but it was lunch time, and she was in a hurry. NA-C stated she used hand	F 880		

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F 880	Continued From page 19 sanitizer in the kitchenette after removing her gloves. NA-C then walked to a sink across from the nursing station, washed her hands with soap and water, and then stated there weren't very many hand sanitizers around here. It was noted there was no hand sanitizer in the kitchenette. During an interview on 6/3/25 at 1:53 p.m., NA-D stated she had infection prevention training through her agency, on the computer, and with showing how she used personal protective equipment (PPE). During an interview on 6/5/25 at 8:27 a.m., the DON stated she told her staff all the time, there were no gloves allowed in the hallway, and they need to clean their hands before and after gloving. The facility policy Hand Washing dated 2/2024, identified proper hand washing techniques should be used to protect the spread of infection. The policy identified "hand washing shall be completed after changing incontinent products or cleaning up after someone who has used the toilet". Catheter Care R10's quarterly MDS dated 5/27/25, identified moderately impaired cognition and diagnoses of benign prostatic hyperplasia and nocturia. R10 had a condom catheter (an external male catheter) and was always incontinent of urine. R10 needed maximum assist with toilet hygiene.	F 880		

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F 880	Continued From page 20 R10's provider order dated 9/18/23, identified a condom catheter at resident bedtime, around 7:00 p.m., and it was ok to keep on during the day. R10's care plan dated 9/20/18, identified functional bladder incontinence with an intervention to use a condom catheter at night and during the day as needed, check for irritation or sores prior to application of new condom catheter. During an observation on 6/4/25 at 9:03 a.m., after putting on and gloves, NA-F removed the urine collection bag out of the blue privacy bag and pulled the tubing loose from the condom catheter, held the tube up so the remaining urine drained down into the collection bag. NA-F then opened the spout on the drainage bag, wiped the spout with an alcohol wipe and drained the urine into a graduate cylinder. Once the bag was empty, NA-F coiled up the tube and placed the collection bag and tube into the blue privacy bag and explained she would leave it in the bag, it was considered hidden if it was in that bag. During an interview on 6/4/25 at 11:55 a.m., LPN-A stated for R10, they need to rinse out the bag and tubing before placing it back into the privacy bag. LPN-A added the tubing gets changed on Saturday nights for everyone. During an interview on 6/5/25 at 8:27 a.m., the DON she would expect the catheter bag and tubing to be rinsed out before they were stored. A policy was requested but not received.	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245471	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/04/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW SHORES LLC	**402 - 13TH AVENUE TWO HARBORS, MN 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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on June 4, 2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Waterview Shores, 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/30/2025

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

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
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:

1. 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.

Building Info:
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

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K 000	Continued From page 2 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 41 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the	K 222		7/3/25

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K 222	Continued From page 3 Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 222		

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K 222	Continued From page 4 Based on observation and staff interview, the facility failed to maintain the proper operation of exit door locking device system per NFPA 101 (2012 edition), Life Safety Code, section 7.2.1.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/04/2025 at 11:25 AM, it was revealed by observation the Exit Door by Room 108 failed to latch when tested. An interview with Maintenance Director verified this deficient finding at the time of discovery	K 222	K222 Egress Doors Immediate Corrective Action:¿¿¿ Exit door by room 108 was repaired so that it latches. Corrective Action as it applies to others:¿¿ Exit doors were audited to ensure they latched. Date of Compliance: 7/3/2025 Recurrence will be prevented by:¿¿Exit doors will be audited weekly x4, monthly x2 to ensure all exit doors latch. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by:¿ Administrator or Designee	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101	K 511		7/3/25

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K 511	Continued From page 5 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Gas and Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.2.2 and NFPA 54 (2012 edition), National Fuel Gas Code, sections 9.2.2 and 10.3.2.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/04/2025, at 11:15 AM, it was revealed by observation that the electrical panel B at the Nursing Station was not secured. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	K353 Sprinkler System – Maintenance and Testing Immediate Corrective Action:¿¿¿Storage materials were removed from within 18” of the sprinkler system in the linen closet. Corrective Action as it applies to others:¿¿All other storage areas were surveyed to ensure items were not stored above 18” of the sprinkler system. Date of Compliance: 7/3/2025	

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K 511	Continued From page 6	K 511	Recurrence will be prevented by:¿¿Storage areas will be audited weekly x4, monthly x2 to ensure items are not impeding above 18” of the sprinkler system. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by:¿ Administrator or Designee	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245471	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**6/4/2025**

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. This deficient finding could an isolated impact on the residents within the facility. Findings include: On 06/04/2025, at 11:45 AM, it was revealed by observation that storage materials had been placed within 18" of the sprinkler system within the Linen Closet.. An interview with the Maintenance Director verified this deficient finding at the time of discovery.

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The above isolated deficiencies pose no actual harm to the residents

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 20, 2025

Administrator
The Waterview Shores LLC
402 - 13th Avenue
Two Harbors, MN 55616

Re: State Nursing Home Licensing Orders
Event ID: 89V311

Dear Administrator:

The above facility was surveyed on June 2, 2025 through June 5, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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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	00844	A. BUILDING: _____ B. WING _____	06/05/2025

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/2/25-6/5/25, a 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 Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. 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 surveyors 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	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 270	MN Rule 4658.0090 Use of Oxygen A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to secure an oxygen tank in a resident room for 1 of 1 resident (R32) reviewed for accidents. Findings include: R32's quarterly Minimum Data Set (MDS) dated 5/14/25, identified R32 had diagnoses which included chronic obstructive pulmonary disease (COPD [a group of lung diseases that block airflow and make it difficult to breath]), depression and anxiety. In addition, R32 was cognitively intact and required substantial to maximum assistantance with activities of daily living. R32's undated Order Summary Report identified R32 had an order for oxygen two to four liters via nasal cannula. R32's care plan dated 2/13/25, identified R32 had an alteration in oxygen/gas exchange related to COPD. Interventions included to monitor oxygen saturations as ordered and as needed and to administer oxygen as ordered.	2 270	Corrected	7/3/25

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2 270	Continued From page 3 During an observation on 6/2/25 at 1:58 p.m., R32 was seated in his wheel chair in his room wearing oxygen via nasal cannula at one liter. During an observation on 6/3/25 at 11:14 a.m., in R32's room an oxygen tank was observed free standing near a stationary oxygen holder that contained five other oxygen tanks. The maintenance director (M)-A was present and verified oxygen tanks should always be secured in a holder for safety. M-A stated the tank if knocked over could turn into a missile and go through walls. During and interview on 6/3/25 at 11:22 a.m., the associate administrator verified oxygen tanks should always be secured and not free standing for safety. During an interview on 6/5/25 at 10:21 a.m., licensed practical nurse (LPN) verified staff received oxygen train as part of hazard training. During an interview on 6/5/25 at 12:58 p.m., the director of nursing (DON) verified oxygen tanks should never be left free standing. The DON verified the danger was the oxygen tank could tip over and go through a wall. A policy on oxygen storage was requested but not provided. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures on storing oxygen; could educate all appropriate staff on the policies and procedures; and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 270		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW SHORES LLC	402 - 13TH AVENUE TWO HARBORS, MN 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) COMPLETE DATE
2 270	Continued From page 4 (21) days.	2 270		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure Section N of the Minimum Data Set (MDS) was accurately coded for 1 of 3 residents (R7) reviewed for unnecessary medications. Findings include: R7's quarterly MDS dated 3/6/25, identified a diagnosis of diabetes mellitus. Section N, which covers medications received during the assessment period, identified R7 was given insulin injections two times during the look back period. R7's provider order, identified dulaglutide subcutaneous solution (a GLP-1 receptor agonist, which is not insulin) 0.5 milliliters (ml)/5 milligrams (mg) to be injected one time a week every Wednesday related to diabetes mellitus, and was not taking any inslun during the look back period During an interview on 6/4/25 at 12:56 p.m., licensed practical nurse (LPN)-A reviewed R7's	2 550	Corrected	7/3/25

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2 550	Continued From page 5 medication list and confirmed R7 didn't take insulin. During an interview on 6/5/25 at 3:38 p.m., registered nurse (RN)-A, an MDS coordinator, stated section N was coded inaccurately for R7. RN-A stated accurately coding the MDS was important because it reflected the plan of care for the resident. A policy regarding MDS completion and accuracy was requested but not received. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure oxygen tanks were secured at all times; and could educate all appropriate staff on the policies and procedures; and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	21025	Corrected	7/3/25

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21025	Continued From page 6 review, the facility failed to ensure food temperatures were monitored prior to and during meal service to prevent risk of food-borne illness. This had the potential to affect all 42 residents residing at the facility. Findings include: During observation on 6/3/25 at 8:40 a.m., residents were being served breakfast. Breakfast consisted of scrambled eggs, sausage, and cinnamon rolls. Eggs and sausage were in aluminum foil inside of crock pots on both units of the facility. Crock pots were set to the "warm" setting. Staff served residents individually and plated their requested food from the crock pots. Staff did not check the temperature of the food during the breakfast service. During observation on 6/4/25 at 7:12 a.m., residents were being served breakfast. Breakfast consisted of biscuits and gravy. Gravy was in the crock pots on east and west units of the facility. Crock pots set to the "warm" setting. During observation on 6/4/25 at 7:58 a.m., both crock pots were still on and set to "warm" setting. During observation on 6/4/25 at 8:31 a.m., both crock pots were still on and set to "warm" setting. During observation on 6/4/25 at 9:29 a.m., both crock pots were still on and set to "warm" setting. During observation on 6/4/25 at 10:15 a.m., both crock pots were still on and set to "warm" setting. During observation on 6/4/25 at 10:31 a.m., east unit crock pot was off and empty. West unit crock pot was on and set to "warm" setting.	21025		

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21025	Continued From page 7 During interview on 6/4/25 at 11:36 a.m., dietary aide (DA)-A stated dietary staff were responsible for bringing out breakfast in the morning. DA-A further stated they did not check breakfast food temperatures and was unsure of who did. During interview on 6/4/25 at 11:45 a.m., corporate dietary manager (CDM) stated concerns with using crock pots for food service. CDM explained temperature control was difficult with the crock pots. CDM further stated temperature control was important to food service in order to prevent food-borne illness. During interview on 6/5/25 at 9:11 a.m., nursing assistant (NA)-A stated dietary staff bring out breakfast and put into crock pots. NA-A further stated they never had to temp breakfast. The breakfast temperature logs were requested but not provided. Per email with administrator on 6/5/25 at 10:23 a.m., "Thank you for bringing the breakfast temps to our attention. We have food log temps, however it appears that breakfast was not a meal included with this." The facility Food Preparation and Service policy revised April 2019, indicated "proper hot and cold temperatures are maintained during food service.' Policy also instructed 'the temperatures of foods held in steam tables are monitored throughout the meal by food and nutrition services staff." SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to food temperatures were monitored during meal service to prevent risk of food-borne illness; and could educate all appropriate staff on the policies and	21025		

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21025	Continued From page 8 procedures; and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21025		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure alcohol-based hand sanitizer was in use in the hand hygiene dispensers throughout the facility. In addition, the facility failed to ensure shared equipment was disinfected between residents for 1 of 2 residents (R9) observed to use a lift; failed to ensure staff completed appropriate hand hygiene and glove use for 2 of 4 residents (R1, R22) observed during cares; failed to ensure the overnight urine collection bag was cleaned prior to storage for 1 of 1 residents (R10) reviewed for catheter care. Findings include: Facility Hand Sanitizer During an observation on 6/3/25 at 3:40 p.m., the hand sanitizer in a free standing black eco lab stand felt like water and did not have an alcohol odor. A staff member opened the hand sanitizer compartment and the container was labeled as	21375	Corrected	7/3/25

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21375	Continued From page 9 benzalkonium. The associate administrator and the director of nursing (DON) were present and both stated they were not aware the product was not an alcohol based product. The associate administrator went to see what kind of product was in resident rooms and confirmed it was the same eco lab product in the resident room with the benzalkonium product. This had the potential to affect all residents residing in the facility, as all resdient rooms had the eco lab product in the wall mounted dispensers. During an interview on 6/4/25 at 8:25 a.m., the nurse consultant (NC)-E verified the benzalkonium product was five to nine percent alcohol and hand sanitizer products needed to be at least 65% alcohol based. The label on the hand sanitizer product identified it as Ecolab DigiSan with the active ingredient as benzalkonium chloride 0.1%. The Centers for Disease Control (CDC) Handsanitizer guidelines and recommendations dated 3/12/24, identified the following: "Hand Sanitizer Guidelines and Recommendations Key the following points: - Washing hands with soap and water is the best way to get rid of germs in most situations. - If soap and water are unavailable, use a hand sanitizer with at least 60% alcohol to clean your hands. - You can tell if the sanitizer contains at least 60% alcohol by checking the product label." The facility policy Hand Washing dated 2/2024, identified hands should be washed "before eating food", and "Alcohol-Based Hand Sanitizers (ABHS) - ABHS should not be used as a	21375		

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21375	Continued From page 10 replacement for proper hand washing when hands are visibly soiled. If, however, hands are not visibly soiled, or soap and water are not available, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used to quickly reduce the number of germs on hands." The undated Ecolab manufacurers indications for benzalkonium chloride 0.1%. identified that "Food code-compliant hand sanitizer gel that reduces the level of bacteria on hands for use between soap and water hand washing. This formula is more than 99.5% effective in in-vitro testing against a broad range of foodborne illness-causing bacteria." and is appropriate for kitchen use. Equipment Disinfection R9's quarterly Minimum Data Set (MDS) dated 3/17/25, identified R9 had diagnoses which included heart failure, urinary retention, diabetes mellitus, , and dementia. In addition, R9 had moderate cognitive impairment and was dependent on staff for activities of daily living including bed to wheel chair transfers. During an observation on 6/3/25 at 2:21 p.m., NA-C was observed bringing R9 into her room, NA-C exited the room. A sign was posted on the outside door which identified the resident was on enhanced barrier precautions. On 6/3/25 at 2:26 p.m., NA-C brought a mechanical lift into R9's room, came out and put on an isolation gown and put on gloves and went back into the room closing the door. On 6/3/25 at 2:49 p.m., NA-C brought the	21375		

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21375	Continued From page 11 mechanical lift out of R9's room and parked in against the wall. There were not any cleaning wipes in the pocket on the mechanical lift. On 6/3/25 at 2:56 p.m., NA-C stated nights cleans the mechanical lifts. NA-C stated she wiped the machine down after using it with the skin care wipes that were in the room. NA-C verified R9 was on enhanced barrier precautions. On 6/5/25 at 12:59 p.m., the DON stated she would expect staff to clean lift equipment after use, she verified it was not acceptable to disinfect the equipment with the personal care wipes used for resident cares. A policy on equipment disinfection was requested but not provided. Hand Hygeine, Glove Use R1 R1's quarterly MDS dated 4/2/25, identified R1 had diagnoses which included broken left hip prosthesis sequela, open left hip joint, morbid obesity, acquired absence of left hip joint, depression, anxiety, and schizophrenia. R1's had mild cognitive impairment, was dependent on staff for activities of daily living, had no rejections of care, and had a surgical wound. R1's care plan was requested but not provided. On 6/4/25 at 10:22 a.m., NA-D and NA-G put on isolation gowns and gloves and entered R1's room after knocking. NA-D and NA-G rolled R1 to his right side and NA-G cleaned stool from the buttocks using disposable wipes. NA-F then applied protective ointment to R1's buttocks,	21375		

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21375	Continued From page 12 without removing the soiled gloves. R1 had more stool which was cleaned again by NA-G who then placed a new brief and pad and took the protective ointment tube and reapplied the ointment, without changing gloves or providing hand hygiene, R1 was rolled to his back. NA-D then took the protective ointment from NA-G and applied the ointment to R1's right hip. Both NA's removed their gloves, isolation gowns, performed hand hygiene with hand sanitizer and exited the room. During an interview on 6/4/25 at 10:43 a.m., NA-G verified they should have changed gloves and sanitize their hands after cleaning a resident who had a bowel movement. NA-G verified they did not do this during cares. During an interview on 6/5/25 at 12:59 p.m., the DON stated she would expect staff to change their gloves and wash their hands after cleaning a resident who'd had a bowel movement. R22: R22's annual MDS dated 4/2/25, identified R22 had severe cognitive impairment and diagnoses of dementia, palliative care, limitation of activities due to disability, and low back pain. R22 needed extensive assist with bed mobility, was non-ambulatory, dependent for transfers, frequently incontinent of bowel and occasionally incontinent of urine. R22's care plan was not provided. On 6/3/25 at 11:45 a.m., NA-D and NA-C were assisting R22 with incontinence, after removing her soiled brief and having her use the commode. Both NAs were wearing gloves. NA-C used a	21375		

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21375	Continued From page 13 cloth to provide peri care, first to the front and then to the back. NA-D assisted to hold R22 on her right side while NA-C tucked a clean brief underneath R22 while wearing the same gloves she provided peri care with. Both NAs worked together to get R22's pants on, and the sling for the lift centered underneath her. NA-C positioned R22's wheelchair underneath her while NA-D operated the lift controls, and once seated both NAs removed the loops from the sling. NA-C picked up and moved the commode out of the way, opened the door to the hall, grabbed a hold of the sling lift, all while wearing the same gloves, and brought the lift out into hall. NA-C left the lift along the side of the hall, walked across the hall to the kitchenette, removed her gloves and threw them in a trash can, then turned and grabbed a coffee cup off a table and walked toward the dining room. During interview on 6/3/25, at 12:15 p.m. NA-C stated she would normally wash her hands after removing gloves, but it was lunch time, and she was in a hurry. NA-C stated she used hand sanitizer in the kitchenette after removing her gloves. NA-C then walked to a sink across from the nursing station, washed her hands with soap and water, and then stated there weren't very many hand sanitizers around here. It was noted there was no hand sanitizer in the kitchenette. During an interview on 6/3/25 at 1:53 p.m., NA-D stated she had infection prevention training through her agency, on the computer, and with showing how she used personal protective equipment (PPE). During an interview on 6/5/25 at 8:27 a.m., the DON stated she told her staff all the time, there were no gloves allowed in the hallway, and they	21375		

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21375	Continued From page 14 need to clean their hands before and after gloving. The facility policy Hand Washing dated 2/2024, identified proper hand washing techniques should be used to protect the spread of infection. The policy identified "hand washing shall be completed after changing incontinent products or cleaning up after someone who has used the toilet". Catheter Care R10's quarterly MDS dated 5/27/25, identified moderately impaired cognition and diagnoses of benign prostatic hyperplasia and nocturia. R10 had a condom catheter (an external male catheter) and was always incontinent of urine. R10 needed maximum assist with toilet hygiene. R10's provider order dated 9/18/23, identified a condom catheter at resident bedtime, around 7:00 p.m., and it was ok to keep on during the day. R10's care plan dated 9/20/18, identified functional bladder incontinence with an intervention to use a condom catheter at night and during the day as needed, check for irritation or sores prior to application of new condom catheter. During an observation on 6/4/25 at 9:03 a.m., after putting on and gloves, NA-F removed the urine collection bag out of the blue privacy bag and pulled the tubing loose from the condom catheter, held the tube up so the remaining urine	21375		

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21375	Continued From page 15 drained down into the collection bag. NA-F then opened the spout on the drainage bag, wiped the spout with an alcohol wipe and drained the urine into a graduate cylinder. Once the bag was empty, NA-F coiled up the tube and placed the collection bag and tube into the blue privacy bag and explained she would leave it in the bag, it was considered hidden if it was in that bag. During an interview on 6/4/25 at 11:55 a.m., LPN-A stated for R10, they need to rinse out the bag and tubing before placing it back into the privacy bag. LPN-A added the tubing gets changed on Saturday nights for everyone. During an interview on 6/5/25 at 8:27 a.m., the DON she would expect the catheter bag and tubing to be rinsed out before they were stored. A policy was requested but not received. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure the hand sanitizer was at least 60% alcohol, shared equipment was disinfected after use, hand hygiene was followed during cares, and overnight urine collection bag was cleaned prior to storage; and could educate all appropriate staff on the policies and procedures ; and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		