DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 21, 2023

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

Re: Reinspection Results
Event ID: 8RE512

Dear Administrator:

On September 21, 2023 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 July 27, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 21, 2023

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

RE: CCN: 245471
Cycle Start Date: July 27, 2023

Dear Administrator:

On September 21, 2023, the Minnesota Departments 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 23, 2023

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

RE: CCN: 245471
Cycle Start Date: July 27, 2023

Dear Administrator:

On July 27, 2023, 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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 27, 2023 (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 27, 2024 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	C 07/27/2023

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 7/24/23 to 7/27/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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 7/24/23 to 7/27/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed: H5471038C (MN82732) H54713856C (MN94050) H54713855C (MN94376) H54713870C (MN88102) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an	F 000		

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

Electronically Signed | 08/31/2023

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 000	Continued From page 1 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to update the care plan of resident's choice of code status for 1 of 5 residents (R20)	F 657	F657 (SS=D) Care Plan Timing and Revision	9/13/23

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F 657	Continued From page 2 reviewed for care planning. Findings include: R20's quarterly Minimum Data Set (MDS) assessment, dated 5/29/23, indicated R20 was cognitively intact with diagnoses of left-sided hemiplegia and hemiparesis after a cerebral vascular accident (CVA), obstructive and reflux uropathy, muscle weakness, dysphagia (difficulty in swallowing), chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension, and anemia. R20's care plan, dated 6/27/22, indicated the current code status as full code (meaning chest compressions and lifesaving efforts) with the goal being that R20's choices will be honored during the review period with an intervention for staff to follow physician's order for life sustaining treatment (POLST) guidelines. R20's POLST form, signed by R20 on 2/21/23 and signed by his medical doctor on 2/22/23, indicated R20's choice for code status was to be Do Not Resuscitate (DNR). A review of R20's electronic health record (EHR) on 7/24/23 read his code status as DNR. During an interview on 7/27/23 at 10:24 a.m., the director of nurses (DON) stated in the case of an emergency, staff would check the residents EHR for the current code status. The DON confirmed the care plan addresses resident's choice for code status and this is updated quarterly with MDS and with changes in resident status. The DON would expect the code status in EHR to match the code status in the care plan so that	F 657	Immediate Corrective Action: Care plan code status updated for R20. Corrective Action as it applies to others: Care Plans, Comprehensive Person-Centered Policy reviewed and remains current. All residents POLSTs and Care Plans were reviewed to ensure that items match. Nursing leadership educated on Care Plans, Comprehensive Person-Centered Policy with specifics regarding ensuring that POLSTs and Care Plan match. Date of Compliance: 9/13/2023 Recurrence will be prevented by: All residents POLSTs and Care Plans will be reviewed to ensure that they match weekly x4 weeks and then, monthly x2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: DON or Designee	

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F 657	Continued From page 3 there are no discrepancies in a resident's wishes. A document titled Care Plans, Comprehensive Person-Centered, indicated the care plan was developed by the interdisciplinary team (IDT) in conjunction with the resident and their family or legal representative and reflect the resident's expressed wishes regarding care and treatment goal's.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident's care plan was implemented for 1 of 5 residents (R14) reviewed for care planning. Findings include: R14's Minimum Data Set (MDS) assessment, dated 7/6/23, indicated severe cognitive impairment with diagnoses of cerebrovascular disease, history of falling, difficulty in walking, open angle glaucoma, and hearing loss. R14's MDS further indicated a risk for falls, a history of falls, the need for extensive assistance with bed mobility, transfers, locomotion, dressing, toilet use and personal hygiene. R14's care plan (CP), dated 12/12/21, indicated R14 was at risk for falls, with an intervention to	F 658	F658 (SS=D) Services Provided Meet Professional Standards Immediate Corrective Action: Staff members responsible were re-educated on need to follow a resident's care plan. Corrective Action as it applies to others: Care Plans, Comprehensive Person-Centered Policy reviewed and remains current. All residents' safety care plans were reviewed to ensure that all fall interventions remain appropriate. Nurses, TMAs, and CNAs were educated on the Care Plans, Comprehensive Person-Centered Policy specifically regarding following care planned interventions.	9/13/23

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F 658	Continued From page 4 wear gripper socks at bedtime. A progress note, dated 7/12/23 at 12:21 a.m., indicated R14 was found on the floor with his walker next to his bed and had no gripper socks on. During an interview, on 7/26/23 at 10:21 a.m., the corporate consultant (CC)-A and the director of nurses (DON) verified R14 was at risk for falls and had a history of falls. In review of R14's most recent fall on 7/11/23, the DON verified R14's CP was not being followed as he was not wearing gripper socks as the CP indicated. During an interview on 7/27/23 at 9:54 a.m., the DON stated education had been given to staff during shift-to-shift report about the importance of following resident care plans. An undated facility policy, titled Care Plans, Comprehensive Person-Centered, indicated the care plan was a comprehensive, person-centered plan that includes measurable objectives and described the services to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. A request for staff re-education regarding following the CP was requested but not received.	F 658	Date of Compliance: 9/13/2023 Recurrence will be prevented by: Audits of 3 residents per week will be completed to ensure that staff are following the resident's individual care plan with regards to safety interventions x4 weeks and then, monthly x2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: DON or Designee	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		9/13/23

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F 686	Continued From page 5 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning in a timely manner to prevent reoccurrence of skin breakdown for 1 of 6 (R6) residents observed who were at risk for pressure ulcer. Findings include: R6's Face Sheet, indicated R6 had diagnoses of dementia, vitamin B12 deficiency anemia, hypothyroidism, pain in thoracic spine, depression, myasthenia gravis (a weakness and rapid fatigue of muscles under voluntary control), anxiety, and glaucoma (a group of eye conditions that can cause blindness). R6's annual Minimum Data Set (MDS) assessment dated 6/12/23, indicated R6 was severely cognitively impaired and required extensive assistance with activities of daily living. In addition, R6's MDS indicated she was at risk for pressure ulcer. R6's care plan initiated on 5/2/23, indicated R6 was at risk for alteration in skin integrity related to age and skin turgor (refers to the elasticity of your skin, sometimes used to test for dehydration). R6's care plan also indicated she had a history of	F 686	F686 (SS=D) Treatment/Services to Prevent/Heal Pressure Ulcer Immediate Corrective Action: Repositioned R6 according to current care plan and reviewed care plan to ensure it is still appropriate for R6. Corrective Action as it applies to others: Repositioning Policy reviewed and remains current. All residents were reviewed to ensure that they have an appropriate repositioning intervention on their care plan and that the specific guidelines are listed on the resident’s CNA care guide. Nurses, TMAs, and CNAs were educated on the Repositioning Policy specifically regarding following a resident’s individualized repositioning plan. Date of Compliance: 9/13/2023 Recurrence will be prevented by: Audits of 5 residents will be reviewed weekly x4 weeks and then, monthly x2 months to ensure that residents are being repositioned per their individualized care	

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F 686	Continued From page 6 skin tears and pressure ulcer to coccyx. Interventions included to pad, protect and/or apply skin prep to fragile skin, keep skin cleaned and dry, pressure reduction support surface in bed and in wheelchair. R6's care plan lacked an intervention of turning and repositioning. R6's nursing assistant care guide not dated, directed staff to; "reposition and off load every two hours, offer to lay down after meals due to impaired skin on her bottom." On 7/26/23 a continuous observation was started: -at 6:58 a.m., R6 was lying in bed on her back. -at 9:05 a.m., a staff member looked into her room but did not enter. -at 9:32 a.m., a staff member looked into her room from the doorway but did not enter, R6 remained on her back in bed. -at 10:05 a.m., nursing assistant (NA)-D and licensed practical nurse (LPN)-C entered R6's room for a skin check. R6 was flat on her back, her buttocks were pink, blanchable with no open areas. R6's brief was wet. Perineal care was provided, a new brief was placed, and R6 was positioned on her right side. During an interview on 7/26/23 at 10:04 a.m., LPN-C verified three hours was too long for R6 to be on her back with no repositioning. During an interview on 7/26/23 at 10:18 a.m., NA-D verified R6 was on her back when she went into the room with LPN-C. NA-D was unsure of when R6 had last been repositioned, she had not received report from nights but thought maybe NA-A had.	F 686	plan. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: DON or Designee	

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F 686	Continued From page 7 During an interview on 7/26/23 at 10:28 a.m., NA-A verified R6 had last been repositioned at 5:30 a.m. and should have been repositioned every two hours. During an interview on 7/27/23 at 12:47 p.m., the director of nursing (DON) verified R6 should be repositioned every two to three hours to prevent skin breakdown. The DON verified R6 had previously had skin breakdown on her coccyx. The policy Repositioning dated 5/2013, indicated the purpose of the policy was to prevent skin breakdown, promote circulation and provide pressure relief for residents, particularly for those who were bed or chair bound. In addition, the policy indicated "repositioning is critical for a resident who is immobile or dependent upon staff for repositioning."	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 690		9/13/23

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F 690	Continued From page 8 catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow infection control practices during cares of an indwelling urinary catheter (a flexible tube that is inserted into the bladder to drain urine from the bladder) to prevent the risk of urinary tract infection for 2 of 3 residents (R30, R8) reviewed for catheter care. Findings include: R30's admission Minimum Data Set (MDS) assessment, dated 6/29/23, indicated severe cognitive impairment with diagnoses of non-traumatic brain dysfunction, non-Alzheimer's dementia, and urinary retention. R30's MDS further indicated the need for extensive assistance with personal hygiene and toilet use.	F 690	F690 (SS=D) Bowel/Bladder Incontinence, Catheter, UTI Immediate Corrective Action: All nurses and CNA responsible were educated on changing gloves and washing hands in between and using alcohol to swab the end of the tubing when changing the catheter bag. Corrective Action as it applies to others: The Indwelling Catheter Care Policy and Disinfection of Urinary Drainage Bag Policy were reviewed and remain current. All residents who utilize catheters were reviewed to ensure that all drainage bags and tubing are currently not sitting on floor and are hanging up and are not at risk for	

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	245471	A. BUILDING _____ B. WING _____	C 07/27/2023

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F 690	Continued From page 9 R30's Care Area Assessment (CAA) worksheet, dated 6/29/23, indicated an indwelling urinary catheter was in place. R30's care plan, dated 6/28/23, indicated an alteration in elimination related to urinary retention with a goal for resident to be free from signs and symptoms of a urinary tract infection (UTI). The care plan indicated to follow the policy for Foley catheter care. During an observation on 7/26/23 at 7:41 a.m., with gloved hands licensed practical nurse (LPN)-A changed R30's indwelling urinary catheter from an overnight collection bag to a leg bag. After changing the catheter collection bags, LPN-A continued wearing the same gloves and moved to opening R30's closet door and a drawer removed clean clothes. LPN-A then moved on to changing R30's brief and providing perineal care, and with the same pair of gloves opened the drawer and put the wipes back, used the remote to adjust the bed, picked up and moved the fall mat next to R30's bed and then proceeded to remove gloves and perform hand hygiene. During an interview on 7/26/23 at 12:01 p.m., LPN-A confirmed she did not clean the connections of the catheter tubing with alcohol prior to connecting the tubing. LPN-A verified she did not change her gloves or wash her hands before moving from a dirty area (catheter care and perineal care) to a clean area (picking out clothes, opening drawers, etc.). LPN-A stated her normal practice was change gloves, wash hands and use alcohol to clean the catheter tubing ends because they are important for infection control. During an interview on 7/27/23 at 9:59 a.m., the	F 690	contamination. Items will be replaced if contaminated. Nurses, TMAs, and CNAs were educated on the Indwelling Catheter Care Policy and Disinfection of Urinary Drainage Bag Policy with specific attention on changing gloves and washing hands in between ADL tasks to prevent infection, process for disinfecting urinary drainage bags, hanging up bags and tubing when not in use in a way to prevent infection, and disinfecting both ends of tubing when changing out bags. Date of Compliance: 9/13/2023 Recurrence will be prevented by: Audits of 3 residents who utilize catheters will be competed weekly x4 weeks, and then, monthly audit x2 months to ensure that staff are changing gloves and washing hands at appropriate intervals during catheter care, disinfecting urinary catheter bags, hanging up bags and tubing when not in use in an appropriate location, and disinfecting both ends of tubing when changing out bags. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: DON or Designee.	

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F 690	Continued From page 10	F 690		

director of nursing (DON) stated she would expect the ends of the catheter connections to be cleaned with alcohol when changing between an overnight and a leg bag, and to change gloves and wash hands when moving from a dirty area to a clean area to help prevent infection.

A facility policy, titled Indwelling Catheter Care Procedure dated 7/21/23, indicated to remove gloves and perform hand hygiene after performing catheter care.

R8
R8's quarterly minimum data set (MDS) assessment dated 4/21/23, indicated R8 was moderately cognitively impaired, and diagnoses included: hydrocephalus, hypertension, anemia, anxiety, major depression, dementia, CVA, generalized weakness, and benign prostatic hyperplasia.

R8's care plan indicated R8 preferred to wear a condom catheter at night and instructed staff to offer R8 the use of the toilet when he woke up, and then every 2 hours while awake.

R8's Provider orders directed staff to place condom catheter on R8 when R8 was in bed around 7:00 p.m.

During an observation and interview on 7/24/23 at 1:46 p.m., R8 stated he wore a condom catheter bag at night. R8's catheter drainage bag and tubing were in R8's bathroom hanging on the plumbing at the back of the toilet. The open end of the drainage system did not have a cap on it. There was a pink bin on the floor beside the toilet that contained a syringe and graduated cylinder, a gallon jug of vinegar was on the shower floor.

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F 690	Continued From page 11 During an observation on 7/25/23 at 11:04 a.m., R8 was in bed. There were two graduated cylinders in R8's bathroom in a pink bucket on top of a shower chair in R8's shower. During an interview on 7/25/23 at 11:07 a.m., NA-C stated catheter bag cleaning included wiping the tubing ends with alcohol wipes and then cleaning the bag with a vinegar and water mix. During an observation on 7/25/23 at 2:57 p.m., R8 was dressed and eating a snack while seated in a wheelchair. There was a large catheter drainage bag sitting in a pink bin on a shower chair in R8's bathroom shower. The tubing end that connected to the condom catheter was visible and not capped. On 7/26/23 at 7:17 a.m., R8 was sitting up in bed eating breakfast. During an observation on 7/26/23 at 9:54 a.m., nursing assistant (NA)-C and registered nurse (RN)-A entered R8's room, sanitized hands and put on gloves. RN-A removed R8's condom catheter wiping the skin as the condom rolled down. RN-A disconnected the condom catheter from the drainage bag and went to bathroom to get some needed supplies. -at 9:57 a.m. NA-C washed and dried R8's peri area. RN-C returned bedside, emptied R8's catheter bag into a graduated cylinder, placed the bag into a pink bin and went into the bathroom with it. RN-C walked out of the bathroom putting on new gloves. -at 9:58 a.m. while at bedside NA-C assisted R8 on his side. NA-C washed and applied barrier	F 690		

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F 690	Continued From page 12 cream to R8's buttocks. -at 9:59 a.m. NA-C removed gloves and remained at bedside. RN-A secured a clean brief. NA-C went into the bathroom did not sanitize hands, and applied new gloves. RN-C wearing same gloves, picked R8's clothes he chose to wear. NA-C washed hands in sink left room and returned with a standing lift. The standing lift was utilized to transfer R8 from bed to chair. -at 10:07 a.m. RN-A started to assist R8 with washing face and upper body cares. Left the room -at 10:08 a.m. NA-C went into bathroom put on gloves and mixed vinegar and water in a graduated cylinder. NA-C stated the mix calculation was 100 milliliters (ml) of vinegar to 200ml of water. NA-C hung the catheter drainage bag on the toilet pipe coming out of the wall. NA-C used a 30ml syringe to draw up the vinegar solution, connected syringe to open end of the tubing and filled the catheter bag. Once the bag was full of solution, NA-C emptied solution into the toilet, removed the bag from the back of the toilet pipe, coiled the drainage bag tubing without capping the end, placed it in a pink bin on a paper towel, and then set it on a shower chair in the shower. Before exiting the room, NA-C removed gloves and sanitized hands. -at 10:10 a.m., RN-A returned to the room sanitized hands and shaved R8. When done RN-A removed gloves, sanitized hands, and then exited the room. During an interview on 7/26/23 at 10:19 a.m., RN-A stated after she removed R8's condom catheter she sanitized her hands in the bathroom before she re-gloved. RN-A stated she had used the hand sanitizer she kept in her pocket because	F 690		

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F 690	Continued From page 13 there wasn't any hand sanitizer in R8's bathroom like there usually was. RN-A stated she did not need to wash her hands after R8's brief was secured and before using the lift because she still had her gloves on. On 7/26/23 at 10:36 a.m., NA-C confirmed she did not sanitize her hands before putting on new gloves after peri-care was performed. NA-C stated she would normally do that but there was not hand sanitizer in the bathroom. NA-C stated hands always needed to be sanitized after peri care was completed and indicated hands should also be sanitized between gloves getting changed to prevent contamination and infection spread. During an observation on 7/27/23 at 10:16 a.m., R8's bed pan was sitting on the bathroom floor next to the toilet plunger on a plastic bag. There was a graduated cylinder sitting in the bed pan. R8's Foley drainage bag and tubing were coiled up and in the graduated cylinder sitting in the bed pan on the floor. On 7/27/23 at 11:33 a.m., the director of nursing (DON) entered R8's bathroom. The Foley catheter was in the graduated cylinder, in the bedpan on the floor. The DON stated the bed pan should be off the floor in a bag, and the catheter drainage bag should definitely not be shoved into a graduated cylinder and placed in a bed pan. The DON stated she would expect staff to clean and store the drainage bag per policy. The DON confirmed storing the bag in a pink bin or graduated cylinder, or on the back of the toilet where it was exposed to toilet flushes was unsanitary and not acceptable because it put the bag at risk for contamination and created a risk for infection spread. The DON stated when staff	F 690		

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F 690	Continued From page 14 hung the bag to dry the open end of the drainage bag should not touch any surfaces, but indicated she would need to research if it was best practice to cap the end of the open tubing. Facility policy Disinfection of Urinary Drainage bag dated 12/15 instructed the following to prevent the growth of bacteria: Clean daily when urinary drainage bag is removed from resident. Hand sanitize, uncap bottom outlet drain urine into measuring system and recap outlet, dispose of urine in toilet, dispose of gloves, sanitize, and apply new gloves. Before disconnecting tubing, clean both ends of catheter and tubing with alcohol wipes (to prevent bacteria from entering the catheter end when the bag is disconnected) Do not contaminate the tubing ends by touching other surfaces. Connect the catheter bag to the tubing. Remove gloves and dispose. Make resident comfortable and document urine. Remove the top cap. Partially fill the bag with 55-65 cc of vinegar. Shake gently so the entire bag is rinsed well, then drain the vinegar from bag. Store bag on clean towel or in clear plastic bag until next use; allowing exterior to air dry. Wash your hands. Change out bag for a new appliance on shower day.	F 690		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		9/13/23

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F 757	Continued From page 15 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications administered had an adequate indication and diagnoses for use for 1 of 5 residents (R7) reviewed for medications. Findings included: R7's Face Sheet, indicated R7 had diagnoses of diabetes mellitus, difficulty walking, depression, hypertension, repeated falls, and adult failure to thrive. R7's quarterly Minimum Data Set (MDS) assessment dated 5/26/23, indicated R7 was moderately cognitively impaired, hallucinated and delusions and rejected care one to three days. In addition, R7 required extensive assistance with transfers, dressing, toilet use, and personal hygiene.	F 757	F757 (SS=D) Drug Regimen is Free from Unnecessary Drugs Immediate Corrective Action: Request sent to physician for appropriate diagnosis for R7's aspirin, atorvastatin, lisinopril, and metformin. Corrective Action as it applies to others: Medication and Treatment Orders Policy was reviewed and remains current. All residents' current medications were reviewed to ensure that they have an appropriate diagnosis or indication for use listed in the order. All staff responsible for transcription of provider orders for medications were educated on the need to ensure that that resident has an appropriate diagnosis or indication for use listed in every	

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F 757	Continued From page 16 R7's Physician Order dated 7/27/23, directed the following medications to be given: -aspirin (a nonsteroidal anti-inflammatory drug and blood thinner) 81 milligrams (mg) give by mouth in the morning. The order lacked a diagnosis and indication for use. -atorvastatin (used to treat high cholesterol and tryglycerides) 40 mg give by mouth at bedtime. The order lacked a diagnosis and indication for use. -lisinopril (can treat high blood pressure and heart failure) 40 mg give by mouth at bedtime. The order lacked a diagnosis and indication for use. -metformin (anti-diabetic medication) 1000 mg give by mouth two times a day. The order lacked a diagnosis and indication for use. During an interview on 7/27/23 at 1:36 p.m. the director of nursing (DON) verified the medication orders lacked a diagnosis and indication for use. The DON stated she would want the provider to identify a reason for the medication.	F 757	medication order. Date of Compliance: 9/13/2023 Recurrence will be prevented by: Audits of 5 residents' medications including any new admissions will be completed weekly x4 weeks and then, monthly audit x2 months to ensure that all medications have an appropriate diagnosis or indication for use listed on the order. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: DON or Designee	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician	F 759	F759 (SS=D) Free of Medication Error Rate 5% or More	9/13/23

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F 759	Continued From page 17 orders for 2 of 7 residents (R17, R11) observed to receive medication during the survey. This resulted in a facility medication error rate of 8%. Findings include: R17's Face Sheet, indicated R17 had diagnoses of dementia, chronic obstructive pulmonary disease (COPD [a group of lung diseases that block airflow and make it difficult to breathe]). R17's quarterly Minimum Data Set (MDS) assessment indicated she was severely cognitively impaired. R17's Physician Order Summary Report active orders as of 7/27/23, included: -budesonide-formoterol fumarate aerosol 160-4.5 mcg/ACT two inhalations orally every morning and at bedtime related to COPD. Rinse mouth after each use. During an observation on 7/24/23 at 6:07 p.m., licensed practical nurse (LPN)-B brought R17 her medications which included budesonide-formoterol fumarate aerosol inhaler. LPN-B shook the inhaler gave R17 one puff waited one minute gave R17 a second puff but did not offer R17 water to rinse and spit after using the inhaler. During an interview on 7/24/23 at 6:48 p.m. LPN-B verified she should have had R17 rinse her mouth after using her inhaler. R11 R11's Face Sheet indicated diagnoses of	F 759	Immediate Corrective Action: LPN and TMA responsible were re-educated on need to follow special instructions on resident medications. Corrective Action as it applies to others: The Medication and Treatment Orders Policy was reviewed and remains current. All nurses and TMAs were educated on the Medication and Treatment Orders Policy with specific focus on following special instructions on resident medications during administration. Date of Compliance: 9/13/2023 Recurrence will be prevented by: Audits of medication passes for 3 residents will be completed weekly x4 weeks and then, monthly audit x2 months to ensure that all medications are administered per MD order and special medication instructions. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: DON or Designee	

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F 759	Continued From page 18 hemiplegia and hemiparesis (weakness/paralysis on one side of the body) following cerebrovascular disease affecting right dominant side, cerebral infarction (stroke), depression, aphasia (loss of ability to understand or express speech), mild cognitive impairment, hypertension, chronic post traumatic stress disorder, diabetes mellitus, and dysphagia (impairment in the production of speech). R11's Physician Order Summary Report active orders as of 7/27/23, included: -baclofen 10 mg, give by mouth in the afternoon for muscle spasms take with food -baclofen 10 mg, give by mouth in the morning for muscle spasms take with food -baclofen 15 mg give by mouth in the evening for muscle spasms take with food During an observation on 7/25/23 at 3:06 p.m. trained medication aide (TMA)-A gave R11 baclofen 15 mg with water no food or snack was provided. During an interview on 7/25/23 at 3:11 p.m., TMA-A verified she should have provided R11 a snack with his baclofen as indicated on the medication card. During an interview on 7/27/23 at 11:38 a.m., the consultant pharmacist (CP)-C verified the budesonide-formoterol fumarate aerosol inhaler contained a steroid and therefore after each use the resident should rinse their mouth and spit so they minimize the risk of getting thrush (a fungal infection on the mucous membranes which can cause mouth pain).	F 759		

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F 759	Continued From page 19 During an interview on 7/27/23 at 12:45 p.m., the director of nursing (DON) verified residents using inhalers with steroids need to rinse and spit after use to prevent the development of thrush. The DON stated she would expect staff to follow instructions to give medications with food if directed to this in the orders.	F 759		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 23, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 8RE511

Dear Administrator:

The above facility was surveyed on July 24, 2023 through July 27, 2023 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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00844	A. BUILDING: _____ B. WING _____	07/27/2023

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
2 000	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 7/24/23 to 7/27/23, 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. The following complaints were reviewed during the survey: H5471038C (MN82732) H54713856C (MN94050) H54713855C (MN94376) H54713870C (MN88102) 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.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with	2 302		9/13/23

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2 302	Continued From page 3 Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 8 of 8 employees had completed the facility Alzheimer's and dementia care training program. This had the potential to affect all residents in the facility. Findings include: Objectives on Alzheimer's training provided by the facility indicated staff would be able to list three symptoms of Alzheimer's disease, list two risk factors for Alzheimer's disease and state two methods used for diagnosing Alzheimer's disease. The course failed to have information on	2 302	Corrected	

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2 302	Continued From page 4 assistance with activities of daily living, problem solving with challenging behaviors, and communication skills needed to work with those with Alzheimer's disease. On 7/28/23 at 11:13 a.m., the director of nursing (DON) sent slides for the Alzheimer's course. On 7/28/23 at 2:24 p.m., an email was sent to the DON asking for specific slides . No further communication was received. The admission packet indicated the facility would provide training on Alzheimer's and aging upon hire and annually. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all required areas of Alzheimer's training were covered for all staff. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must	2 835		9/13/23

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2 835	Continued From page 5 be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to follow infection control practices during cares of an indwelling urinary catheter (a flexible tube that is inserted into the bladder to drain urine from the bladder) to prevent the risk of urinary tract infection for 2 of 3 residents (R30, R8) reviewed for catheter care. Findings include: R30's admission Minimum Data Set (MDS) assessment, dated 6/29/23, indicated severe cognitive impairment with diagnoses of non-traumatic brain dysfunction, non-Alzheimer's dementia, and urinary retention. R30's MDS further indicated the need for extensive assistance with personal hygiene and toilet use. R30's Care Area Assessment (CAA) worksheet, dated 6/29/23, indicated an indwelling urinary catheter was in place. R30's care plan, dated 6/28/23, indicated an alteration in elimination related to urinary retention with a goal for resident to be free from signs and symptoms of a urinary tract infection (UTI). The care plan indicated to follow the policy for Foley catheter care. During an observation on 7/26/23 at 7:41 a.m., with gloved hands licensed practical nurse (LPN)-A changed R30's indwelling urinary catheter from an overnight collection bag to a leg bag. After changing the catheter collection bags, LPN-A continued wearing the same gloves and	2 835	Corrected	

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2 835	Continued From page 6 moved to opening R30's closet door and a drawer removed clean clothes. LPN-A then moved on to changing R30's brief and providing perineal care, and with the same pair of gloves opened the drawer and put the wipes back, used the remote to adjust the bed, picked up and moved the fall mat next to R30's bed and then proceeded to remove gloves and perform hand hygiene. During an interview on 7/26/23 at 12:01 p.m., LPN-A confirmed she did not clean the connections of the catheter tubing with alcohol prior to connecting the tubing. LPN-A verified she did not change her gloves or wash her hands before moving from a dirty area (catheter care and perineal care) to a clean area (picking out clothes, opening drawers, etc.). LPN-A stated her normal practice was change gloves, wash hands and use alcohol to clean the catheter tubing ends because they are important for infection control. During an interview on 7/27/23 at 9:59 a.m., the director of nursing (DON) stated she would expect the ends of the catheter connections to be cleaned with alcohol when changing between an overnight and a leg bag, and to change gloves and wash hands when moving from a dirty area to a clean area to help prevent infection. A facility policy, titled Indwelling Catheter Care Procedure dated 7/21/23, indicated to remove gloves and perform hand hygiene after performing catheter care. R8 R8's quarterly minimum data set (MDS) assessment dated 4/21/23, indicated R8 was moderately cognitively impaired, and diagnoses included: hydrocephalus, hypertension, anemia, anxiety, major depression, dementia, CVA,	2 835		

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2 835	Continued From page 7 generalized weakness, and benign prostatic hyperplasia. R8's care plan indicated R8 preferred to wear a condom catheter at night and instructed staff to offer R8 the use of the toilet when he woke up, and then every 2 hours while awake. R8's Provider orders directed staff to place condom catheter on R8 when R8 was in bed around 7:00 p.m. During an observation and interview on 7/24/23 at 1:46 p.m., R8 stated he wore a condom catheter bag at night. R8's catheter drainage bag and tubing were observed in R8's bathroom hanging on the plumbing at the back of the toilet. The open end of the drainage system did not have a cap on it. There was a pink bin on the floor beside the toilet that contained a syringe and graduated cylinder, a gallon jug of vinegar was on the shower floor. During an observation on 7/25/23 at 11:04 a.m., R8 was in bed. There were two graduated cylinders in R8's bathroom in a pink bucket on top of a shower chair in R8's shower. During an interview on 7/25/23 at 11:07 a.m., NA-C stated catheter bag cleaning included wiping the tubing ends with alcohol wipes and then cleaning the bag with a vinegar and water mix. During an observation on 7/25/23 at 2:57 p.m., R8 was dressed and eating a snack while seated in a wheelchair. There was a large catheter drainage bag sitting in a pink bin on a shower chair in R8's bathroom shower. The tubing end that connected to the condom catheter was	2 835		

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2 835	Continued From page 8 visible and not capped. On 7/26/23 at 7:17 a.m., R8 was sitting up in bed eating breakfast. During an observation on 7/26/23 at 9:54 a.m., nursing assistant (NA)-C and registered nurse (RN)-A entered R8's room, sanitized hands and put on gloves. RN-A removed R8's condom catheter wiping the skin as the condom rolled down. RN-A disconnected the condom catheter from the drainage bag and went to bathroom to get some needed supplies. -at 9:57 a.m. NA-C washed and dried R8's peri area. RN-C returned bedside, emptied R8's catheter bag into a graduated cylinder, placed the bag into a pink bin and went into the bathroom with it. RN-C walked out of the bathroom putting on new gloves. -at 9:58 a.m. while at bedside NA-C assisted R8 on his side. NA-C washed and applied barrier cream to R8's buttocks. -at 9:59 a.m. NA-C removed gloves and remained at bedside. RN-A secured a clean brief. NA-C went into the bathroom did not sanitize hands, and applied new gloves. RN-C wearing same gloves, picked R8's clothes he chose to wear. NA-C washed hands in sink left room and returned with a standing lift. The standing lift was utilized to transfer R8 from bed to chair. -at 10:07 a.m. RN-A started to assist R8 with washing face and upper body cares. Left the room -at 10:08 a.m. NA-C went into bathroom put on gloves and mixed vinegar and water in a graduated cylinder. NA-C stated the mix calculation was 100 milliliters (ml) of vinegar to 200ml of water. NA-C hung the catheter drainage bag on the toilet pipe coming out of the wall.	2 835		

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2 835	Continued From page 9 NA-C used a 30ml syringe to draw up the vinegar solution, connected syringe to open end of the tubing and filled the catheter bag. Once the bag was full of solution, NA-C emptied solution into the toilet, removed the bag from the back of the toilet pipe, coiled the drainage bag tubing without capping the end, placed it in a pink bin on a paper towel, and then set it on a shower chair in the shower. Before exiting the room, NA-C removed gloves and sanitized hands. -at 10:10 a.m., RN-A returned to the room sanitized hands and shaved R8. When done RN-A removed gloves, sanitized hands, and then exited the room. During an interview on 7/26/23 at 10:19 a.m., RN-A stated after she removed R8's condom catheter she sanitized her hands in the bathroom before she re-gloved. RN-A stated she had used the hand sanitizer she kept in her pocket because there wasn't any hand sanitizer in R8's bathroom like there usually was. RN-A stated she did not need to wash her hands after R8's brief was secured and before using the lift because she still had her gloves on. On 7/26/23 at 10:36 a.m., NA-C confirmed she did not sanitize her hands before putting on new gloves after peri-care was performed. NA-C stated she would normally do that but there was not hand sanitizer in the bathroom. NA-C stated hands always needed to be sanitized after peri care was completed and indicated hands should also be sanitized between gloves getting changed to prevent contamination and infection spread. During an observation on 7/27/23 at 10:16 a.m., R8's bed pan was sitting on the bathroom floor next to the toilet plunger on a plastic bag. There was a graduated cylinder sitting in the bed pan.	2 835		

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2 835	Continued From page 10 R8's foley drainage bag and tubing were coiled up and in the graduated cylinder sitting in the bed pan on the floor. On 7/27/23 at 11:33 a.m., the director of nursing (DON) entered R8's bathroom. The foley catheter was in the graduated cylinder, in the bedpan on the floor. The DON stated the bed pan should be off the floor in a bag, and the catheter drainage bag should definitely not be shoved into a graduated cylinder and placed in a bed pan. The DON stated she would expect staff to clean and store the drainage bag per policy. The DON confirmed storing the bag in a pink bin or graduated cylinder, or on the back of the toilet where it was exposed to toilet flushes was unsanitary and not acceptable because it put the bag at risk for contamination and created a risk for infection spread. The DON stated when staff hung the bag to dry the open end of the drainage bag should not touch any surfaces, but indicated she would need to research if it was best practice to cap the end of the open tubing. Facility policy Disinfection of Urinary Drainage bag dated 12/15 instructed the following to prevent the growth of bacteria: Clean daily when urinary drainage bag is removed from resident. Hand sanitize, uncap bottom outlet drain urine into measuring system and recap outlet, dispose of urine in toilet, dispose of gloves, sanitize, and apply new gloves. Before disconnecting tubing, clean both ends of catheter and tubing with alcohol wipes (to prevent bacteria from entering the catheter end when the bag is disconnected) Do not contaminate the tubing ends by touching other surfaces. Connect the catheter bag to the tubing. Remove gloves and dispose. Make resident comfortable and	2 835		

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2 835	Continued From page 11 document urine. Remove the top cap. Partially fill the bag with 55-65 cc of vinegar. Shake gently so the entire bag is rinsed well, then drain the vinegar from bag. Store bag on clean towel or in clear plastic bag until next use; allowing exterior to air dry. Wash your hands. Change out bag for a new appliance on shower day. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure appropriate infection control practices are utilized in the care of catheters. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 835		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and	2 900		9/13/23

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2 900	Continued From page 12 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based observation, interview and document review, the facility failed to provide repositioning in a timely manner to prevent reoccurrence of skin breakdown for 1 of 6 (R6) residents observed who were at risk for pressure ulcer. Findings include: R6's Face Sheet, indicated R6 had diagnoses of dementia, vitamin B12 deficiency anemia, hypothyroidism, pain in thoracic spine, depression, myasthenia gravis (a weakness and rapid fatigue of muscles under voluntary control), anxiety, and glaucoma (a group of eye conditions that can cause blindness). R6's annual Minimum Data Set (MDS) assessment dated 6/12/23, indicated R6 was severely cognitively impaired and required extensive assistance with activities of daily living. In addition, R6's MDS indicated she was at risk for pressure ulcer. R6's care plan initiated on 5/2/23, indicated R6 was at risk for alteration in skin integrity related to age and skin turgor. R6's care plan also indicated she had a history of skin tears and pressure ulcer to coccyx. Interventions indicated to pad, protect and/or apply skin prep to fragile skin, keep skin cleaned and dry, pressure reduction support surface in bed and in wheelchair.	2 900	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00844	A. BUILDING: _____ B. WING _____	07/27/2023

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

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2 900	Continued From page 13 R6's care plan lacked an intervention of turning and repositioning. R6's nursing assistant care guide not dated, directed staff to; "reposition and off load every two hours, offer to lay down after meals due to impaired skin on her bottom." On 7/26/23 a continuous observation was started: -at 6:58 a.m., R6 was lying in bed on her back. -at 9:05 a.m., a staff member looked into her room but did not enter. -at 9:32 a.m., a staff member looked into her room from the doorway but did not enter, R6 remained on her back in bed. -at 10:05 a.m., nursing assistant (NA)-D and licensed practical nurse (LPN)-C entered R6's room for a skin check. R6 was flat on her back, her buttocks were pink, blanchable with no open areas. R6's brief was wet. Perineal care was provided, a new brief was placed, and R6 was positioned on her right side. During an interview on 7/26/23 at 10:04 a.m., LPN-C verified three hours was too long for R6 to be on her back with no repositioning. During an interview on 7/26/23 at 10:18 a.m., NA-D verified R6 was on her back when she went into the room with LPN-C. NA-D was unsure of when R6 had last been repositioned, she had not received report from nights but thought maybe NA-A had. During an interview on 7/26/23 at 10:28 a.m., NA-A verified R6 had last been repositioned at 5:30 a.m. and should have been repositioned every two hours.	2 900		

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2 900	Continued From page 14 During an interview on 7/27/23 at 12:47 p.m., the director of nursing (DON) verified R6 should be repositioned every two to three hours to prevent skin breakdown. The DON verified R6 had previously had skin breakdown on her coccyx. The policy Repositioning dated 5/2013, indicated the purpose of the policy was to prevent skin breakdown, promote circulation and provide pressure relief for residents, particularly for those who were bed or chair bound. In addition, the policy indicated "repositioning is critical for a resident who is immobile or dependent upon staff for repositioning." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents at risk for pressure ulcers have an individualized plan for pressure relief. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of	21426		9/13/23

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21426	Continued From page 15 Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 6 employees (E2, E3, E4, E5, and E6) were properly screened and/or tested for tuberculosis (TB). In addition, the facility failed to ensure 3 of 6 residents (R133, R27, and R24) were properly screened and/or tested for TB. Findings include: E2 was hired 3/15/23, and had a T-spot (test is a type of blood test that measures the immune response to certain antigens) test completed on 3/23/23, however E2's record lacked evidence a symptom screening was completed. E3 was hired 3/9/23, and had T-spot test completed, however E3's record lacked evidence a symptom screening was completed. E4 was hired 2/11/21, received step 1 of the two	21426	Corrected	

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21426	Continued From page 16 step test, however E4's record indicated E4 no step 2 test was completed within the required timeframe. E5 was hired 6/26/23,had a T-spot test completed on 6/29/23, however E5's record lacked evidence a symptom screening was completed. E6 was hired 7/12/23,had a T-spot test completed on 7/12/23, however E6's record lacked evidence a symptom screening was completed. R133 was admitted on 9/6/22. R133's record lacked TB symptom screening and testing. R27 was admitted on 4/8/23. R27 's record lacked a TB symptom screening . R24 was admitted on 12/9/22. R24's record lacked evidence of TB screening . During an interview on 7/27/23 at 11:54 a.m., the director of nursing (DON) confirmed E4 did not receive the second step test timely. And did not have a symptom screening During an interview on 7/27/23 at 1:50 p.m., the DON stated the facility had switched to doing a T-spot test for staff and residents. The DON confirmed upon admission, all residents should get a TB symptom screening and a T-spot test. The DON stated it the facility had stopped doing the TB symptom screening on new employees when the facility switched from the two step TST to the T-spot test. The facility's Tuberculosis (TB) Risk assessment worksheet for Health Care Settings Licensed by MDH dated 7/13/23, indicated the facility performed the required TB screening of all	21426		

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21426	Continued From page 17 personnel at the time of hire and that the facility utilized the T-spot to test. The document also indicated baseline screening and testing was completed at the time of admission for newly admitted residents. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee could review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees. Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions as well as current residents records to ensure compliance. The ICN, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992.	21530		9/13/23

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21530	Continued From page 18 This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications administered had an adequate indication and diagnoses for use for 1 of 5 residents (R7) reviewed for medications. Findings included:	21530	Corrected	

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21530	Continued From page 19 R7's Face Sheet, indicated R7 had diagnoses of diabetes mellitus, difficulty walking, depression, hypertension, repeated falls, and adult failure to thrive. R7's quarterly Minimum Data Set (MDS) assessment dated 5/26/23, indicated R7 was moderately cognitively impaired, hallucinated and delusions and rejected care one to three days. In addition, R7 required extensive assistance with transfers, dressing, toilet use, and personal hygiene. R7's Physician Order dated 7/27/23, directed the following medications to be given: -aspirin (a nonsteroidal anti-inflammatory drug and blood thinner) 81 milligrams (mg) give by mouth in the morning. The order lacked a diagnosis and indication for use. -atorvastatin (used to treat high cholesterol and tryglycerides) 40 mg give by mouth at bedtime. The order lacked a diagnosis and indication for use. -lisinopril (can treat high blood pressure and heart failure) 40 mg give by mouth at bedtime. The order lacked a diagnosis and indication for use. -metformin (anti-diabetic medication) 1000 mg give by mouth two times a day. The order lacked a diagnosis and indication for use. During an interview on 7/27/23 at 1:36 p.m. the director of nursing (DON) verified the medication orders lacked a diagnosis and indication for use. The DON stated she would want the provider to identify a reason for the medication. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could	21530		

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21530	Continued From page 20 develop, review, and/or revise policies and procedures to utilize a process which ensures the diagnoses for a medication is obtained. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or	21545		9/13/23

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21545	Continued From page 21 toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders for 2 of 7 residents (R17, R11) observed to receive medication during the survey. This resulted in a facility medication error rate of 8%. Findings include: R17's Face Sheet, indicated R17 had diagnoses of dementia, chronic obstructive pulmonary disease (COPD [a group of lung diseases that block airflow and make it difficult to breathe]). R17's quarterly Minimum Data Set (MDS) assessment indicated she was severely cognitively impaired.	21545	Corrected	

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21545	Continued From page 22 R17's Physician Order Summary Report active orders as of 7/27/23, included: -budesonide-formoterol fumarate aerosol 160-4.5 mcg/ACT two inhalations orally every morning and at bedtime related to COPD. Rinse mouth after each use. During an observation on 7/24/23 at 6:07 p.m., licensed practical nurse (LPN)-B brought R17 her medications which included budesonide-formoterol fumarate aerosol inhaler. LPN-B shook the inhaler gave R17 one puff waited one minute gave R17 a second puff but did not offer R17 water to rinse and spit after using the inhaler. During an interview on 7/24/23 at 6:48 p.m. LPN-B verified she should have had R17 rinse her mouth after using her inhaler. R11 R11's Face Sheet indicated diagnoses of hemiplegia and hemiparesis (weakness/paralysis on one side of the body) following cerebrovascular disease affecting right dominant side, cerebral infarction (stroke), depression, aphasia (loss of ability to understand or express speech), mild cognitive impairment, hypertension, chronic post traumatic stress disorder, diabetes mellitus, and dysphagia (impairment in the production of speech). R11's Physician Order Summary Report active orders as of 7/27/23, included: -baclofen 10 mg, give by mouth in the afternoon for muscle spasms take with food	21545		

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21545	Continued From page 23 -baclofen 10 mg, give by mouth in the morning for muscle spasms take with food -baclofen 15 mg give by mouth in the evening for muscle spasms take with food During an observation on 7/25/23 at 3:06 p.m. trained medication aide (TMA)-A gave R11 baclofen 15 mg with water no food or snack was provided. During an interview on 7/25/23 at 3:11 p.m., TMA-A verified she should have provided R11 a snack with his baclofen as indicated on the medication card. During an interview on 7/27/23 at 11:38 a.m., the consultant pharmacist (CP)-C verified the budesonide-formoterol fumarate aerosol inhaler contained a steroid and therefore after each use the resident should rinse their mouth and spit so they minimize the risk of getting thrush (a fungal infection on the mucous membranes which can cause mouth pain). During an interview on 7/27/23 at 12:45 p.m., the director of nursing (DON) verified residents using inhalers with steroids need to rinse and spit after use to prevent the development of thrush. The DON stated she would expect staff to follow instructions to give medications with food if directed to this in the orders. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure accuracy in medication administration. The Director of Nursing or designee could educate all appropriate staff on the policies and	21545		

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21545	Continued From page 24 procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		

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	245471	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**07/27/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/27/2023. 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.	K 000		

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

Electronically Signed | 08/31/2023

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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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.

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

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 _____	**07/27/2023**

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	Continued From page 2 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 38 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321		8/31/23

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K 321	Continued From page 3 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/27/2023 between 09:00am and 1:00pm, it was revealed by observation that soil utility room did not close and latch by self-closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321	K321 (D) – Hazardous Areas - Enclosure Soiled utility door repaired and in working order. Date of Compliance: 8/31/2023 Corrections will be monitored by: Administrator or designee.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors	K 363		8/31/23

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K 363	Continued From page 4 to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/27/2023 between 09:00am and 1:00pm it	K 363	K363 (D) – Corridor Doors Immediate Corrective Action: Corridor doors repaired and in working order. Date of Compliance: 8/31/2023 Corrections will be monitored by:	

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K 363	Continued From page 5 was revealed by observation that the following resident room door did not latch: 1) Resident door 107 2) Resident door 127 3) Resident door 119 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 363	Administrator or designee.	
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 741		9/13/23

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K 741	Continued From page 6 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement a staff smoking policy per NFPA 101 (2012 edition), Life Safety Code section 19.7.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/27/2023, 09:00am and 1:00pm, it was revealed by observation that the smoking was occurring by employee entrance as evident by discarded cigarette butts and a visible pack of cigarettes. An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 741	K741 (F) – Smoking Regulations Immediate Corrective Action: Cigarette butts were properly disposed of. Corrective Action as it applies to others: All staff education on smoking regulation and proper smoking areas. Date of Compliance: 9/13/2023 Recurrence will be prevented by: Weekly audit x4 weeks, monthly audit x2 months of campus grounds to inspect for any cigarette butts. Corrections will be monitored by: Administrator or designee.	