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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DWRM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00844

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245471**
2.STATE VENDOR OR MEDICAID NO.
(L2) **048540300**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE WATERVIEW SHORES LLC**
(L4) **402 - 13TH AVENUE**
(L5) **TWO HARBORS, MN** (L6) **55616**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/01/2019**

6. DATE OF SURVEY **04/13/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **44** (L18)
13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 03/30/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 04/08/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
04/12/2021
(L32)

32. DETERMINATION OF APPROVAL DATE
04/13/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 26, 2021

CMS Certification Number (CCN): 245471

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 11, 2021 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 26, 2021

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

RE: CCN: 245471
Cycle Start Date: February 19, 2021

Dear Administrator:

On March 12, 2021, we notified you a remedy was imposed. On April 13, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 11, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 11, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 9, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 11, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 11, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DWRM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00844

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245471**
2.STATE VENDOR OR MEDICAID NO.
(L2) **048540300**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE WATERVIEW SHORES LLC**
(L4) **402 - 13TH AVENUE**
(L5) **TWO HARBORS, MN** (L6) **55616**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/01/2019**

6. DATE OF SURVEY **02/25/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **44** (L18)
13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Sativa Bushey, FNE - NE II 03/30/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 04/08/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
March 12, 2021

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

RE: CCN: 245471
Cycle Start Date: February 19, 2021

Dear Administrator:

On March 9, 2021, we informed you that we may impose enforcement remedies.

On February 25, 2021, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 11, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 11, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 11, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal

notice from the CMS RO only if CMS agrees with our recommendation.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 11, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Waterview Shores Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 11, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 19, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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 02/25/2021

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 2/22/21, through 2/25/21, a survey for compliance with CMS Appendix Z Emergency Preparedness was conducted during a recertification survey. The facility was IN compliance with the Appendix Z Emergency Preparedness, Requirements for Long-Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS On 2/22/21, through 2/25/21, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5471018C H5471019C H5471020C H5471021C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		

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

Electronically Signed | 03/22/2021

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 02/25/2021

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
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the opportunity to participate in the care planning process and be	F 553	F 553 Right to Participate in Planning Care Immediate Corrective Action:	3/29/21

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 02/25/2021

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
F 553	Continued From page 2 included in decisions about care, treatment and/or interventions in the required time frame for 1 of 1 resident (R27) reviewed for care conferences. Findings include: R27's Transfer/Discharge Report printed 2/25/21, indicated R27 was admitted to the facility on 11/11/20, with diagnoses that included cerebral infarction (stroke), atrial fibrillation, hypothyroidism, and palliative care. R27's significant change Minimum Data Set (MDS) dated 1/13/21, indicted R27 had severe cognitive impairment, and it was very important to R27 to have family involved in discussions about R27's care. On 2/22/21, at 5:36 p.m. an interview was conducted with family member (FM)-A. During the interview, FM-A stated she had a few concerns regarding R27's plan of care. FM-A stated R27's last care conference was when R27 was admitted. FM-A stated she had not received a called or received any information regarding any upcoming care conference dates for R27. On 2/25/21, at 10:17 a.m. an interview was conducted with the social service designee (SSD)-A. SSD-A stated care conferences were completed after admission, quarterly, and with a significant change in condition. SSD-A stated R27's last care conference was on 11/25/20, at 1:00 p.m. for R27's admission care conference. SSD-A stated R27 had a significant change in condition and an MDS was completed on 1/13/21. SSD-A verified R27 did not have a care conference with R27's change in condition, and	F 553	Resident #27□s care conference was scheduled to ensure that any issues were addressed and to review current care plan with resident and family. Corrective Action as it applies to others: The social services director will be educated on the need to complete care conferences after admission, quarterly, and with any change in condition. All residents will be reviewed to ensure that they are up to date on their required care conferences. Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of 5 residents□ care conference schedule will be conducted weekly x 4 and then monthly x 2 months to ensure that they received their appropriate care conference. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator Designee/Designee	

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 02/25/2021

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
F 553	Continued From page 3 R27's care conference was not on February's care conference schedule. The SSD-A stated R27 should have had a care conference when R27 had a change in condition. On 2/25/21, 1:17 p.m. an interview was conducted with the director of nursing (DON). The DON stated care conferences were held after admission, quarterly, and when a significant change in a resident's condition had occurred. The DON stated SSD-A scheduled the care conferences and informed residents and/or resident representatives when care conferences were scheduled. The facility policy on Care Conferences was requested and not received.	F 553		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to remove facial hair for 1 of 4 residents (R15) reviewed for assistance with activities of daily living (ADLs). Findings include: R15's Face Sheet printed 2/26/21, indicated R15's diagnoses included unspecified dementia. R15's quarterly Minimum Data Set (MDS) dated 12/15/20, indicated R15 was severely cognitively	F 677	F 677 ADL Care Immediate Corrective Action: Resident #15□s facial hair was removed. Corrective Action as it applies to others: The policy for ADL Assistance per Care Plan Policy was reviewed and remained current. Nurses and CNAs will be educated on the need to provide facial hair removal per care plan/preference. All residents will be reviewed to ask about facial hair removal preferences and care	3/29/21

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 02/25/2021

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
F 677	Continued From page 4 impaired. R15's care plan dated 10/4/19, indicated R15 required extensive assistance of one for all personal care. On 2/22/21, at 6:15 p.m. R15 was observed to have facial hair along the entire base of the chin that were approximately 1/8th of an inch long. A small area to the right of the chin had a cluster of 4-5 hairs that were approximately 1/4 inch long. On 2/23/21, at 1:20 p.m. R15's family member (FM)-A was interviewed. FM-A stated R15 was a beautician for many years, and "would be mortified" if she realized she had facial hair. On 2/24/21, at 7:29 a.m. was observed with eating breakfast. R15's facial hair remained untrimmed. On 2/25/21, at 11:05 a.m. nursing assistant (NA)-G was interviewed. NA-G stated R15 had facial hair, and was not sure when they were last trimmed. NA-G stated facial hair was trimmed on shower days. The facility policy Monarch Healthcare ADL Assistance Per Care Plan revised 5/2018, directed "Based on resident/resident representative desires, assessment and care plan, ADL assistance will be provided to any residents deemed necessary. Some examples would be: Shaving (male and female) as needed."	F 677	plan/NAR care sheets will be updated. Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of 5 residents will be conducted weekly x 4 and then monthly x 2 months to ensure that they had facial hair removed per care plan/preference. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/Nurse Manager/Designee	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities.	F 679		3/29/21

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 02/25/2021

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
F 679	Continued From page 5 §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure meaningful activities of were provided to 1 of 1 residents (R27) reviewed for activities. Findings include: R27's Transfer/Discharge Report printed 2/25/21, indicated R27 diagnoses included cerebral infarction (stroke) and palliative care. R27's significant change Minimum Data Set (MDS) dated 1/13/21, indicted R27's family and religious activities were very important to R27. The MDS further indicated R27 was totally dependent on staff for bed mobility, transfers, dressing, grooming, eating, toileting, and personal hygiene. R27's Therapeutic Recreation Evaluation dated 11/13/20, indicated R1 had clear speech, was very religious, enjoyed Polka and old county music, TV land and ME TV, required frequent or continual prompts/cueing to engage in group process, and program plan was to attend small groups and church.	F 679	F 679 Activities Meet Interest Immediate Corrective Action: Resident #27 and family was interviewed to determine activity preferences to integrate with resident□s care plan. Corrective Action as it applies to others: The Activity Evaluation Policy was reviewed and remained current. Activity Director and activity staff will be educated on need to interview resident/family regarding activity preferences and to integrate them into the resident care plan and to provide activities that are meaningful to the resident. All residents/families will be interviewed regarding activity preferences and these preferences will be integrated into the resident care plan. Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of 5 residents will be conducted weekly x 4 and then monthly x 2 months to ensure that care plan has been updated on activity preferences and are being provided meaningful activities. The results will be shared with the facility QAPI committee for input on the need to	

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 02/25/2021

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
F 679	Continued From page 6 R27's care plan dated 1/7/21, indicated R27 wishes were to be invited and assisted to group programs of interest such as church services. R27's Care Area Assessment (CAA) for cognition loss/dementia dated 1/26/21, identified R21 exhibited short and long-term memory problems and staff need to anticipate R21's wants and needs. A nursing assistant care guide dated 2/22/21, lacked indication of R27's preference to attend church services on Wednesdays. On 2/22/21, at 5:23 p.m. family member (FM)-A stated she was unsure what activities were being offered to R27. FM-A stated R27 was a devoted Catholic and was very religious. FM-A stated she requested for staff to bring R27 to church services on Wednesdays. FM-A stated she would like to see R27 get out of her room a more often and have more human interactions even if it was once a week to go to church. During observations on 2/23/21, at 9:06 a.m. R27 was in was in bed with the lights off and curtain drawn. No music or television was on. During observations on 2/24/21, at 7:09 a.m. R27 was in bed, the lights were off, and the curtain was drawn. At 8:57 a.m. nursing assistant (NA)-H entered R27's room and offered R27 something to drink. R27 declined. R27 remained lying on her back wearing a hospital gown. At 9:15 a.m. R27 was in bed lying on her back. No television or music was on. At 10:25 a.m. R27 was in bed, and the church service was scheduled to begin at 10:30 a.m. No staff offered to bring R27 to church service.	F 679	increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator/Social Services/Designee	

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 02/25/2021

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
F 679	Continued From page 7	F 679		

During observations on 2/25/21, at 8:49 a.m. R27 was in bed wearing a hospital gown and no television or music was on.

On 2/24/21, at 10:36 a.m. FM-B stated when she visited R27, R27 was usually in bed. FM-B stated it would mean a lot to R27 if R27 were to be able to get dressed and brought to church services on Wednesdays. FM-B stated R27 was very spiritual, a devoted catholic, and always wore a dress.

On 2/24/21, at 1:48 p.m. NA-H confirmed she did not ask R27 if she wanted to attend Wednesday church services and further stated she had not seen R27 attend any church service since R27 was admitted. NA-H stated R27 preferred to stay in bed and when offered to get up, R27 refused.

On 2/24/21, at 1:45 p.m. NA-C confirmed R27 did not get out of bed for lunch and was not offered to attend Wednesday church services. NA-C stated R27 would refuse to get up in her chair when offered and preferred to stay in bed. NA-C stated R27 moaned, yelled out, and would complain of pain.

On 2/25/21, at 9:38 a.m. activity director (AD)-A stated activity assessments were completed on admission. AD-A stated one-on-one activities were provided to residents that were unable to attend regular group activities. AD-A stated R27's one-on-one activities included reading books, music, talking, and holding hands. AD-A stated one-on-one visits were not scheduled and she tried to see R27 once weekly for activities. AD-A stated R27 was Catholic and tried to have someone come in monthly to give R27

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 02/25/2021

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
F 679	Continued From page 8	F 679		

communion. AD-A stated she had not seen R27 attend Wednesday church services and was unaware if staff were asking R27 if she would like to attend. AD-A stated R27 was on hospice and preferred to stay in her bed. AD-A stated she was aware religious services were very important to R27, and confirmed R27 should be given an opportunity to attend.

R27's Follow Up Question Report dated 12/27/20 to 2/25/21, indicted the following:
-On 12/20/20, during Religious Service/Bible Study/Prayer activity, R27 passively participated.
-On 1/6/21, during Religious Service/Bible Study/Prayer activity, R27 was not available.
-On 1/20/21, during Religious Service/Bible Study/Prayer activity, R27 was not available.
-On 1/27/21, during Religious Service/Bible Study/Prayer activity, R27 was not available.
-On 2/3/21, during Religious Service/Bible Study/Prayer activity, R27 refused.
-On 2/10/21, during Religious Service/Bible Study/Prayer activity, R27 was not available.
-On 2/19/21, during Religious Service/Bible Study/Prayer activity, R27 was not available.
-On 2/24/21, during Religious Service/Bible Study/Prayer activity, R27 was not available contrary to observation.

On 2/25/21, at 1:21 p.m. AD-A stated documentation of "Not Available" could mean R27 was sleeping or had a visitor. AD-A stated the activity charting system only allowed for selected answers to be chosen from. AD-A confirmed an activity participation selection included "Family/Friend/Visit in the Facility." The AD-A verified, according to R27's Follow Up Question Report dated 12/29/20 to 2/25/21, the majority of R27's activity participation for Religious

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 02/25/2021

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
F 679	Continued From page 9 Service/Bible Study/ Prayer was documented "Resident not available". On 2/25/21, at 1:17 p.m. the director of nursing (DON) stated if a resident refused cares, services, or treatments, staff were expected to report the refusal to the nurse. The DON stated staff were expected to re-approach a resident and document the refusal, and along with interventions tried, in the medical record. The DON stated if a resident's meaningful activity was to attend church she would expect staff to offer the resident an opportunity to attend church. Facility policy titled Activity Evaluation undated, directed an activity evaluation is conducted as part of the comprehensive assessment to help develop an activity plan that reflects the choices and interests of the resident. The policy further directed the resident's lifelong interests, spirituality, life roles, goals, strength, needs and activity pursuit patterns and preferences are included in the evaluation. The completed activity evaluation is updated as necessary but at least quarterly.	F 679		
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	F 690		3/29/21

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 02/25/2021

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
F 690	Continued From page 10 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 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 document review, the facility failed to ensure a comprehensive bladder and bowel assessment had been completed for 1 of 2 residents (R14) reviewed for bowel and urinary incontinence. Findings include: R14's Face Sheet printed 2/25/21, indicated diagnoses of benign prostatic hyperplasia (prostate gland enlargement) without lower urinary tract symptoms, hemiplegia and hemiparesis following cerebral infarction (stroke)	F 690	F 690 Bowel/Bladder Incontinence Immediate Corrective Action: Resident #14 had a comprehensive bowel and bladder assessment completed and care plan/NAR care sheet was updated to reflect toileting schedule. Corrective Action as it applies to others: The Behavior Programs and Toileting Plans for Urinary Incontinence Policy was reviewed and remained current. DON and NM were educated on need to complete a comprehensive bowel and bladder assessment for any annual or	

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 02/25/2021

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
F 690	Continued From page 11 affecting left side, urinary tract infections, and vascular dementia with behavioral disturbance. R14's annual Minimum Data Set (MDS) dated 9/22/20, indicated R14 was cognitively intact, and was extensively dependant on staff for toileting needs, did not have a toileting plan, and was always incontinent of bowel and bladder. R14's Quarterly MDS dated 12/15/20, indicated R14 had a indwelling urinary catheter, and was still incontinent of bowel. R14 was still assessed as being cognitively intact and needing the same level of toileting assistance as R14's prior annual MDS documented. R14's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 10/02/20, indicated, "Incontinent of bowel and bladder. Has a history of [benign prostatic hyperplasia] and takes Flomax [medication used in treating an enlarged prostate] and Finasteride [medication used in treating an enlarged prostate]. Staff offer urinal every 2 hours and as needed. He doesn't ask staff to assist with toileting, unsure if he is aware of his need to void. He is on a check and change schedule with offering the urinal if dry." On 2/22/21, at 5:30 p.m. R14 was observed sitting in bed eating the evening meal he requested. R14 was noted to be sitting on a light yellow disposable soaker (incontinent) pad. On 2/22/21, at 6:15 p.m. R14 was interviewed and stated staff help him with urinal placement. R14 stated the nursing assistants check on him, and he also will place on his call light if he feels the urge to have a bowel movement or urinate.	F 690	change in condition and to update care plan/NAR care sheets with results. All residents will be reviewed to ensure that they have had a timely bowel and bladder assessment and care plan/NAR care sheets with results. Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of 5 residents will be conducted weekly x 4 and then monthly x 2 months to ensure that a comprehensive bowel and bladder assessment has been completed annually and with any significant change and care plan/NAR care sheets have been updated. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/NM/Designee	

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 02/25/2021

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
F 690	Continued From page 12	F 690		

R14 also stated there are times "it just happens." R14 stated that he has issues with bladder infections as well.

R14's MHM Bladder Evaluation (assessment) dated 9/22/20, documented only that R14 was incontinent of bladder, his diagnoses, and medications potentially effecting R14's incontinence. The assessment lacked a comprehensive determination on whether R14 had the potential for reversing/reducing urinary incontinence, did not identify the type of urinary incontinence, lacked documentation that a visual inspection of urethral area was performed, lacked determination of an individual treatment plan, nor was there any form of clinical summary to this assessment.

R14's care plan last reviewed 2/22/21, indicated that the section on R14's bladder needs was last updated on 2/14/2019. The care plan indicated the following: "The resident has FUNCTIONAL bladder incontinence [related to] immobility and a diagnosis of [benign prostatic hyperplasia]. Goal: The resident will be continent at all times though the review date.
Interventions/Tasks:
- Clean peri-area with each incontinence episode
- Continent unless sleeping, check and change at night every 2 hours. Will asked to be toileted. Assist of 1 for urinal, assist of 2 for commode.
- Ensure the resident has unobstructed path to the bathroom
- Establish voiding pattern
- provide medications per MD orders."

R14's incontinence tracking sheets used by the nursing assistants, documented the following:

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 02/25/2021

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
F 690	Continued From page 13	F 690		

2/22/21
Day Shift: 6 AM "X", 8 AM "X", 10 AM incontinent (INC) of bladder, 12 PM blank
Relief Shift: 2 PM small INC of both bowel and bladder, 4 PM blank, 6 PM blank, 8 PM blank
Night Shift: 10:30 PM INC of bladder, 12:30 AM continent, 2:30 AM INC bladder, 4:30 AM continent

2/23/21
Day Shift: 6-8 AM [did not void], 8-10 AM INC of bladder, 10 AM -12 PM "dry", 12 - 2 PM INC of bowel / bladder
Relief Shift: 2 - 4 PM moderate INC of both bowel and bladder, 4 - 6 PM INC of bladder, 6 - 8 PM "dry", 8 - 10 PM blank
Night Shift - 10:30 PM continent, 12:30 AM continent, 2:30 AM continent, 4:30 AM moderate INC of both bowel and bladder

2/24/21
Day Shift: 6-8 AM INC of bladder, 8-10 AM continent, 10 AM -12 PM continent, 12 - 2 PM continent
Relief Shift: 2 - 4 PM dry , 4 - 6 PM "adjusted for supper", 6 - 8 PM large INC of both bowel and 8 - 10 PM blank
Night Shift - 10 PM - 12 AM INC of urine, 12 - 2 AM continent, 2 - 4 AM continent, 4 - 6 AM INC bladder

On 2/24/21, at 9:07 a.m. nursing assistant (NA)-A was interviewed and stated R14 was incontinent of bladder one to two times during a shift, sometimes with bowel. Referring to the care sheet posted at the nurses station, NA-A stated staff offer R14 toileting every two hours, but it may be during a two hour time frame (see documentation above). NA-A stated R14 did not

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 02/25/2021

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
F 690	Continued From page 14	F 690		

always use his call light, and didn't know why.

On 2/24/21, at 11:53 a.m. R14's family member (FM)-A was interviewed and stated R14 has been hospitalized for urinary tract infections over the last year. FM-A stated she did not think R14 was getting enough fluids, because he was on thicken liquids due to aspiration concerns. FM-A stated R14 complained about the taste and texture of thickened liquids.

On 2/24/21, at 11:59 a.m. NA-B was interviewed and stated R14 was incontinent of bladder one to two times a shift, but usually only of urine. NA-B stated R14 did not place his call light on, and staff only know if he needed a urinal place or have a bowel movement when staff entered the room to offer.

On 2/25/21, at 9:57 a.m. a nursing care manager (CM)-A was interviewed and stated in regards to both the bowel and bladder assessments not being completed for R14, nursing assistants indicating R14 was incontinent of urine one to two times a shift, and R14's care plan indicating R14 was "Continent unless sleeping," stated she would review R14's chart.

The facility policy Behavior Programs and Toileting Plans for Urinary Incontinence revised 10/19, directed the purpose of the policy "..is to provide guidelines for the initiation and monitoring of behavioral interventions and/or a toileting plan for a resident with urinary incontinence." The policy had a procedure for assessment, which included monitoring voiding patterns, determining type of incontinence, if a resident is able to comprehend "education efforts and follow through with instructions", such as identification urinary

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 02/25/2021

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
F 690	Continued From page 15 and bowel urge. The policy identified how the facility would be able to assess a resident's ability (cognitive and physical) / willingness to be involved in a toileting plans and training, including "prompted voiding."	F 690		
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 not crush and mixed together (cocktail) or administered together without physician orders and evaluation, to prevent adverse interactions for 3 of 6 residents (R31, R36, R28) reviewed for medication administration. Findings include: R31's Transfer/Discharge Report dated 2/24/21, indicated R31's diagnoses included dementia without behavioral disturbance, myasthenia gravis (a disease that causes weakness in voluntary muscles, such as muscles for swallowing), and thoracic spinal pain. R31's Order Summary Report for active orders as of 2/24/21, included orders for: -Tylenol 325 milligrams (mg); give 2 tablets by mouth 4 times a day - Pyridostigmine Bromide (to decrease weakening of muscles with myasthenia gravis) tablet; give	F 759	F 759 Free of Medication Error >5% Immediate Corrective Action: Nurse involved was immediately educated on that cocktailing of meds is not appropriate unless there is a specific MD order. Corrective Action as it applies to others: The Administering Medications through an Enteral Tube Policy was reviewed and remained current. All nurses/TMAs were educated that cocktailing (mixing) of medications is not appropriate for residents who have a tube feeding unless there is an MD order. Also, educated that medications can□t be crushed and mixed together unless there is an MD order. All residents who receive medications via feeding tube or require crushed medications will have MD notified to determine whether crushing and/or mixing of medications is appropriate for that resident.	3/29/21

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 02/25/2021

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
F 759	Continued From page 16 60 mg by mouth 3 times a day -Ibuprofen Tablet 400 mg by mouth 3 times a day for left foot pain for 14 days -Gabapentin 300 mg by mouth 2 times a day and 600 mg at bedtime related to pain in thoracic spine -regular diet, mechanical soft texture, regular (thin) consistency (liquids), pureed diet, OK for regular texture at breakfast. R31's Order Summary Report lacked indication to crush or cocktail medications. R31's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for 2/21, lacked direction to crush and cocktail medications. On 2/22/21, at 5:57 p.m. licensed practical nurse (LPN)-B was observed preparing R31's medications for administration. Medications included Tylenol, Pyridostigmine, Motrin, and gabapentin. LPN-B put Tylenol, Pyridostigmine and Motrin into a small plastic bag, and crushed them together. LPN-B stated R31 should have an order for crushing medications in the TAR, and said she could not pull up the orders on her computer. LPN-B stated R31 was on a pureed diet, so it was OK to crush her medications together. LPN-B continued to crush the medications together, mixed them with apple sauce, and added the uncrushed gabapentin capsule into the apple sauce. LPN-B then administered the medications to R31, and after persuading, R31 took her medications as prepared. R36's Transfer/Discharge Report dated 2/24/21, indicated R36's diagnoses included Alzheimer's disease, congestive heart failure, atrial fibrillation	F 759	Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of 5 residents will be conducted weekly x 4 and then monthly x 2 months to ensure that any resident who receives crushed medications or medications through a PEG tube are administered individually unless there is an MD order that it is ok to mix and administer together. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/NM/Designee	

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 02/25/2021

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
F 759	Continued From page 17	F 759		

(irregular heart rhythm), moderate protein-calorie malnutrition, and dysphagia (swallowing difficulties).

R36's Order Summary Report for active orders as of 2/24/21, included orders for:
-donepezil; give 10 mg by mouth at bedtime related to Alzheimer's disease
-metoprolol succinate extended release (ER) 24 hour; give 25 mg by mouth every morning and at bedtime related to congestive heart failure
-mirtazapine tablet; give 15 mg by mouth at bedtime related to moderate protein-calorie malnutrition.
-regular diet, puree meat texture, honey consistency liquids.
-medications crushed to pureed consistency every shift related to dysphagia. R31's order lacked directives to cocktail crushed medications together, and which medications could be crushed.

R36's MAR for 2/21, directed to crush medications to pureed consistency every shift related to dysphagia. R36's MAR lacked directions to cocktail crushed medications together and which medications could be crushed.

On 2/22/21, at 6:37 p.m. LPN-C was observed preparing R36's medications for administration, including donepezil, metoprolol succinate ER, and mirtazapine. LPN-C put the medications into a small plastic bag and crushed them together. LPN-C verified R36 had orders for crushing medications on the MAR. LPN-C stated directives could not be on the MAR without an order, and verified R36 did not have orders to crush medications together. LPN-C put the

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 02/25/2021

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
F 759	Continued From page 18	F 759		

crushed medications in applesauce and administered the medications to R36.

R28's Transfer/Discharge Report dated 2/24/21, indicated R28's diagnoses included osteoporosis, atherosclerotic heart disease (ASHD- hardening and narrowing of your arteries), heart failure, major depressive disorder, chronic pain, vitamin D deficiency, constipation, and gastro-esophageal reflux disease (GERD-when stomach acid frequently flows back into the tube connecting the mouth and stomach).

R28's Order Summary Report for active orders as of 2/24/21, included orders for:
-aspirin tablet chewable; give 81 mg in the morning related to chronic atrial fibrillation
-calcium carbonate tablet 600 mg; give 600 mg in the morning related to age-related osteoporosis
-cholecalciferol capsule give 1000 units in the morning related to age-related osteoporosis
-isosorbide mononitrate tablet; give 30 mg every morning and at bedtime related to ASHD
-Lipitor tablet 40 mg; give 40 mg in the morning related to hyperlipidemia
-multivitamin adult tablet; give one table in the morning for supplement
-Norco tablet 5-325 mg; give 1 tablet every morning and at bedtime for chronic back pain
-Norvasc; give 5 mg in the morning related to essential hypertension
-Protonix Tablet delayed release 40 mg; give one tablet in the morning for dissolve and mix in one tsp apple juice related to GERD
-Senna-S Tablet 8.6-50 mg; give one tablet in the morning for constipation
-Zoloft Tablet; give 100 mg in the morning related to major depressive disorder
-NPO diet (nothing by mouth)

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 02/25/2021

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
F 759	Continued From page 19	F 759		

-Medications have to be given one at a time through PEG tube (percutaneous endoscopic gastrostomy tube place directly into the stomach for enteral feeding, hydration and medication administration) with small water flushes in between. DO NOT ADMINISTER MEDICATIONS TOGETHER, order date 4/6/20.

R28's MAR for 2/21, directed to give medications one at a time through the PEG tube with small water flushes in between. DO NOT ADMINISTER MEDICATIONS TOGETHER.

On 2/24/21, at 7:38 a.m. registered nurse (RN)-A was observed preparing R28's medications for administration. RN-A dispensed the medications into two medication cups together, and started to take a plastic bag to put them into for crushing. When asked if medications were to be crushed together, RN-A stopped and said she should probably do one at a time, but said she usually crushed and gave them together. RN-A stated she found the orders to do one medication at a time and proceeded to crush each medication individually and put them in separate medication cups. RN-A brought the crushed medications to R28's room, and after checking R28's PEG tube for residual and flushing the tube with a small amount of water, put approximately 5 to 10 milliliters (ml) into each medication cup and mixed the medications in the water. RN-A poured the medications from each cup into R28's PEG tube one right after another without flushing between each medication. RN-A stated R28 did not have orders to flush between each medication, but her orders said to give one at a time.

On 2/24/21, at 2:45 p.m. the director of nursing

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 02/25/2021

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
F 759	Continued From page 20	F 759		

(DON) was interviewed and stated R28's medications should be crushed individually and administered individually, and verified R28's MAR directed to give each medication individually separated by water. The DON stated they follow medication orders when residents are admitted from the hospital, if it says do not crush, and put it on the MAR. The DON stated otherwise it was nursing judgement, as they have it on their standing orders. The DON stated they get an order from the physician to crush medications. The DON also stated the pharmacist reviewed medications and indicated if they need to be separated.

On 2/25/21, at 12:10 p.m. the consultant pharmacist (CP)-A stated medications should not be co-mingled when crushed, because you just don't know what kind of interactions they may have. CP-A stated the nursing staff should get an order to crush and have the pharmacist review for crushing and cocktailing crushed medications. CP-A stated they should not be crushing extended-release medication, as they would not get the proper effect from the medication. CP-A stated they have reviewed R28's medications to be crushed, and verified they should be administered separately and have a water flush between each medication. CP-A stated he had not reviewed other residents for crushing medications, and reviewed R31 and R36's medication observed to be crushed at this time. CP-A stated he would review their medications for crushing.

The facility policy Crushing Medications revised 4/18, directed the medical director, DON and CP would identify appropriate indications and procedures for crushing medications, and

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 02/25/2021

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
F 759	Continued From page 21 directed nursing or CP to notify the ordering physician to crush a medication when the manufacturer advised a medication should not be crushed, such as long-acting or enteric coated medication. The policy directed the physician or CP must identify an alternative medication and/or dosage form, document why crushing medications will not adversely affect the resident, provide justification why the dosage form modification will not compromise the resident, and the nursing staff will observe the resident for pertinent adverse effects. The MAR must indicate why it is necessary to crush medications. The policy further directed medications should be crushed separately and administered with food, and addressed that sometimes giving them separately may not be appropriate for a resident. The facility policy Administering Medications through an Enteral Tube revised 11/18, directed nursing to administer each medication separately and flush between medications, and ensure medications are not on the "Do Not Crush Medication List" with the pharmacy. The policy further directed to flush with 15 ml water between medications.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		3/29/21

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 02/25/2021

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
F 761	Continued From page 22 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper labeling on medications for 1 of 6 residents (R28) reviewed for medication administration. Findings include: R28's Transfer/Discharge Report dated 2/24/21, indicated R28's diagnoses included osteoporosis, atherosclerotic heart disease (ASHD- hardening and narrowing of your arteries), heart failure, major depressive disorder, chronic pain, vitamin D deficiency, constipation, and gastro-esophageal reflux disease (GERD-when stomach acid frequently flows back into the tube connecting the mouth and stomach). R28's Order Summary Report for active orders as of 2/24/21, included orders for: -calcium carbonate tablet 600 mg; give 600 mg in the morning related to age-related osteoporosis,	F 761	F 761 Label/Store Drugs and Biologicals Immediate Corrective Action: Resident #28□s medication card was updated to reflect the current dosage/instructions. Corrective Action as it applies to others: The Labeling of Medications Policy was reviewed and remained current. All nurses/TMAs were educated on the need to ensure that their medication cards match the order before administering the medication(s). All residents□ medication cards will be reviewed to ensure that medication cards match the current orders. If they don□t match, a sticker will be placed on the card to notify nurse/TMA of a medication change and to check chart and pharmacy will be updated. Date of Compliance: 3/29/21 Recurrence will be prevented by:	

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 02/25/2021

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
F 761	Continued From page 23 order date 4/6/20. -Norco tablet 5-325 mg; give 1 tablet every morning and at bedtime for chronic back pain, order date 4/6/20. -Medications have to be given one at a time through PEG tube (percutaneous endoscopic gastrostomy tube place directly into the stomach for enteral feeding, hydration and medication administration) with small water flushes in between. DO NOT ADMINISTER MEDICATIONS TOGETHER, order date 4/6/20. On 2/24/21, at 7:38 a.m. registered nurse (RN)-A was observed preparing R28's medications for administration. RN-A prepared medications to administer to R28. RN-A dispensed one 500 milligram (mg) tablet of Oyster Shell Calcium into a medication cup. RN-A read the label and compared it with the Medication Administration Record (MAR) and stated R28's MAR stated R28 was to receive one 600 mg tablet of calcium, but the pharmacy sent the 500 mg tablets. RN-A said she would call the physician to notify them that the resident received the wrong medication dosage. When asked what she would do when the label did not match the orders, she said they put stickers on the medication to alert nursing to check the medication orders. RN-A stated she would call the pharmacy, also. R28's medication bottle indicated R28's bottle of calcium had been sent from the pharmacy on 2/20/21, and had contained 30 tablets. RN-A counted the remaining tablets, and indicated 27 had remained after she had dispensed one, indicating 2 tablets of the wrong dose had been previously administered. RN-A stated she would give the 500 mg tablet, since it was less than the prescribed dose, and then notify the physician. In addition, R28's Norco 5-325 mg label read to	F 761	Audits of 5 residents will be conducted weekly x 4 and then monthly x 2 months to ensure that the medication cards match the current orders. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/NM/Designee	

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 02/25/2021

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
F 761	Continued From page 24 administer one tablet twice daily as needed for pain. R28's orders indicated R28's Norco was scheduled for twice daily. RN-A stated R28 had received new orders. On 2/24/21, at 2:45 p.m. the director of nursing (DON) verified medication labels should match the orders, and the pharmacy should be notified if they did not match. The facility policy Labeling of Medications dated 12/19, directed all medications in the facility would be properly labeled in accordance with the current state and federal regulations, and nursing would inform the pharmacy of any changes in physician orders for a medication.	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the	F 791		3/29/21

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 02/25/2021

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
F 791	Continued From page 25 dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental services were available for 1 of 1 residents (R5) reviewed for dental services. Findings include: R5's Face Sheet printed 2/25/21, indicated R5's diagnoses included idiopathic hydrocephalus, dementia, major depressive disorder, and Alzheimer's disease. R5's Minimum Data Set (MDS) dated 2/16/20, indicated R5 had moderately impaired cognition.	F 791	F 791 Routine/Emergency Dental Services Immediate Corrective Action: Resident #5 had dental appointment set up. Corrective Action as it applies to others: The Availability of Services, Dental Policy was reviewed and remained current. Social Services Director was educated on need to assist with setting up dental services when needed. All residents were interviewed/assessed to see if they are in need of dental services and social services will ensure that they have dental appointment set up	

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 02/25/2021

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
F 791	Continued From page 26 On 1/3/21, at 11:07 a.m. a progress note indicated R5 was eating popcorn, when one of the front permanent teeth broke. The tooth was saved, R5's spouse was notified. On 1/5/21, at 12:55 p.m. a progress note indicated R5 had complaints of pain related to the broken tooth. A dental visit was being looked at. R5 had no difficulty eating. On 1/7/21, at 12:17 p.m. a progress note indicated a dental appointment was still in the works. R5 had not been having troubles with eating, and denied pain. R5's Oral/Dental Evaluation dated 2/15/21, at 5:40 p.m. indicated Summary/Interventions: "Has a new broken tooth, denies pain and a dental visit is being set up for him. No problems with eating." On 2/23/21, at 12:03 p.m. R5 was interviewed and stated his tooth has been broken since early January. R5 stated he "has not heard anything in weeks about dental appointment." R5 stated the tooth was not painful, but it had been bothersome and embarrassing because it was a front tooth, and"everyone can see it." On 2/24/21, 12:32 pm. R5's family member (FM)-B was interviewed and stated, " The nurses are working on getting [R5] to a dentist, [R5] needs to go to Ely. There is a dentist in Ely that will accept his insurance. There is no dentist in Two Harbors that will accept Medicaid insurance." FM-B stated it was not possible for her to transport R5 to the dentist. FM-B stated she did not know the status of the dental appointment or transportation, she has not heard back from facility.	F 791	if requested/needed in a timely manner. Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of 5 residents will be conducted weekly x 4 and then monthly x 2 months to ensure that if they are in need of dental services that a dental appointment is being set up in a timely manner. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator Designee/Designee	

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 02/25/2021

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
F 791	Continued From page 27 On 2/24/21, 11:25 p.m. case manager (CM)-A was interviewed and stated she did not know R5 had a dental issue. On 2/24/21, 1:57 p.m. social service (SS)-A was interviewed. SS-A stated area dentists refuse to accept all insurances, the dentist in Ely was one of a few who would accept R5's. SS-A stated finding transportation was also difficult. SS-A stated Ely was over an hour away, and transport companies will transport to Ely, but drivers will not wait for a resident. SS-A stated a health unit coordinator (HUC-B) had been working on setting up an appointment and arranging transportation, however, she had resigned the first week of February. The facility policy Availability of Services, Dental dated 8/07, directed "Dental services are available to all residents routine and emergency dental care."	F 791		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		3/29/21

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 02/25/2021

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
F 880	Continued From page 28 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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 02/25/2021

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
F 880	Continued From page 29 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper personal protection equipment (PPE) was donned (put on) before entering a resident's room on quarantine for 1 of 1 resident (R29) reviewed for transmission-based precautions. In addition, the facility failed to ensure proper handling of soiled linen, and hand hygiene was performed during personal cares to prevent cross contamination for 1 of 4 residents (R39) reviewed for personal cares. Findings include: R29's Transfer/Discharge Report printed 2/25/21, indicated R29 diagnoses included congestive heart failure, and asthma. R29's admission Minimum Data Set (MDS) dated 1/26/21, indicated R29 was cognitively intact. R29's Discharge Instructions dated 2/22/21, indicated R29 was was hospitalized from 2/18/21, to 2/22/21, and returned to the care center on 2/22/21.	F 880	F 880 Infection Control Immediate Corrective Action: Signage on resident #29□s room was updated to reflect current guidelines for PPE use. NAR responsible for the breach in infection control during surveyor observation was immediately educated on appropriate process for handwashing, glove changes, and carrying soiled items out of room. Corrective Action as it applies to others: The Soiled Laundry and Bedding Policy was reviewed and remained current. All facility staff including therapy were educated on need to follow the signage on the doors regarding PPE use. Nurses and CNAs are being educated on the need to change gloves and wash hands in going between tasks before touching other items/areas as well as placing soiled items in a bag before leaving a room and throwing them in the appropriate receptacle. All resident rooms who are quarantine or isolation will be reviewed to ensure that	

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 02/25/2021

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
F 880	Continued From page 30 On 2/24/21, at 10:56 a.m. physical therapist (PT)-A and occupational therapist (OT)-A were observed entering R29's room wearing eye protection and a surgical mask, and gloves. PT-A and OT-A did not put on an isolation gown prior to entering R29's room (R29 was on 14-day quarantine after his re-admission from a hospitalization). On 2/24/21, at 10:57 a.m. R29's door was observed to have a stop sign on the outside of R29's door and indicated R29 was on a 14-day quarantine/contact droplet precautions and directed: -Perform hand hygiene before entering and before leaving the room. -Wear gloves a when entering room, and when touching resident, surfaces, or articles in close proximity. -Wear mask when entering room. -Wear gown whenever anticipating that clothing will be in contact with bodily secretions. -Disinfect equipment after use. (blood pressure cuff [BP], thermometers etc). On 2/24/21, at 10:59 a.m. registered nurse (RN)-C stated if physical contact with R29 was anticipated, a gown was to be worn along with eye protection, mask, and gloves. RN-C stated if staff were to go into R29's room for less than 15 minutes and had no physical contact with R29 or the environment, a gown was not needed. On 2/24/21, at 11:05 a.m. nursing assistant (NA)-C knocked and opened R29's door. PT-A and OT-A were observed wearing gloves, eye protection, and a surgical mask. PT-A and OT-A	F 880	the appropriate PPE signage is posted on the door. Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of all residents in isolation or quarantine will be conducted weekly x 4 and then monthly x 2 months to ensure that the appropriate signage is posted on the resident door and that staff entering are wearing appropriate PPE. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Audits of 5 residents will be conducted weekly x 4 and then monthly x 2 months to ensure that staff are changing gloves and washing hands in going between tasks before touching other items/areas as well as placing soiled items in a bag before leaving a room and throwing them in the appropriate receptacle. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/NM/Designee	

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 02/25/2021

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
F 880	Continued From page 31	F 880		

were not wearing gowns and were assisting R29 to stand. NA-C verified he observed R29 in his wheelchair with the walker in front of R29, and PT-A and OT-A were assisting R29 to stand.

On 2/24/21, at 11:19 a.m. PT-A and OT-A exited R29 's room without wearing a gown or gloves and performed hand hygiene.

On 2/24/21, at 11:20 a.m. OT-A and PT-A stated they were working with R29 on endurance and strengthening after R29's returned from the hospital 2/22/21. PT-A stated she was able to get R29 up and out of bed today. OT-A and PT-A stated they were instructed by a director of nursing from another corporate facility, a gown was only needed when coming in contact with bodily fluids. PT-A and OT-A both stated they followed the signage on the resident's door in what PPE to wear. PT-A stated the sign on R29's door directed to wear a gown only when coming in contact with bodily secretions.

On 2/24/21, at 1:58 p.m. speech therapist pathologist (SLP)-A stated eye protection, mask and gloves were to be worn before entering a resident's room on quarantine. SLP-A stated a gown was only needed if coming into contact with a resident's bodily fluids. SLP-A stated she was educated on proper PPE by a DON at another corporate facility.

On, 2/24/21, at 1:59 p.m. housekeeper (H)-A stated when cleaning a quarantine room a gown was not needed since she was not touching a resident. H-A stated only eye protection, gloves, and a mask were needed.

On 2/24/21, at 2:07 p.m. RN-B stated before

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 02/25/2021

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
F 880	Continued From page 32	F 880		

entering a quarantine room eye protection, a mask, gloves, and a gown were needed. RN-B observed the signage outside R29's door and verified the it was incorrect. RN-B stated putting on a gown was required when coming in close contact with R29. RN-B further stated she would remove the sign and print the correct signage for R29's door. RN-B stated the language in the sign was from anther Monarch facility which had been low on PPE. RN-B verified the facility was not low on PPE.

On 2/24/21, 2:13 p.m. the director of therapy (PT)-B stated therapy staff were to follow the guidelines the facility had in place for the proper PPE use.

R39's Transfer/Discharge Report printed 2/25/21, indicated R39's diagnoses included acute kidney failure, and wedge compression fracture of the fourth lumbar vertebra.

R39's admission MDS dated 2/8/21, indicated R39 had moderately impaired cognition and was dependent on staff for toileting and personal hygiene. R39's MDS further indicated he had an indwelling catheter.

On 2/24/21, at 7:39 a.m. during observations of personal cares, NA-H warmed up a wash cloth and handed it to R39 to wash his face. NA-H assisted R39's remove his pants and took a clean wash cloth and wiped and dried R39's perineal area and placed the soiled linens on R39's bed. NA-H disconnected R39's catheter tubing from the drainage bag , disinfected the urinary tubing with an alcohol pad, cleansed the tip of leg bag tubing and attached to the catheter. NA-H measured R39's urinary output from the

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 02/25/2021

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
F 880	Continued From page 33	F 880		

drainage bag, placed the catheter drainage drainage bag in a basin and covered it with a towel. Wearing the soiled gloves, NA-A washed R39's bottom, assisted him to dress, and placed the soiled towels on an extra bed in R39's room. NA-A removed their soiled gloves, did not perform hand hygiene, put on a clean pair of gloves, and assisted R39 into a recliner chair. NA-H made R39's bed, picked up R39's cell phone, plugged it into a charger, placed a tray table in front of R39, and handed R39 his hearing aides. NA-H removed a garbage bag from the garbage can, and put in a new bag. NA-H picked up the dirty linens from the other bed, held them against his chest and arm, and exited R39's room. NA-H carried the bundle of soiled linens down the hallway without bagging, dropped a towel on the hallway floor, and carried the soiled linens to the shower room and placed in the hamper. NA-H then washed hands.

On 2/24/21, at 8:02 a.m. NA-H stated soiled linens should be placed in a plastic bag before leaving a residents room to prevent the spread of infection and dropping linens. NA-H stated soiled linens should be held away from the body to avoid contaminating clothing. NA-H stated gloves should be changed after providing catheter care. NA-H stated hand hygiene should be performed before putting on gloves, after the removal of gloves, and after leaving the resident's room.

On 2/25/21, at 2:32 p.m. the director of nursing (DON) stated staff were expected to wear eye protection, a surgical mask, gloves, and an isolation gown before entering a quarantine room. The DON stated therapy staff were expected to wear a gown in addition to the rest of the PPE as

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 02/25/2021

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
F 880	Continued From page 34	F 880		

therapists often had direct contact with the residents. The DON stated this increased the risk for contaminating clothing and the potential to spread infection to others. The DON stated soiled linen should be handled away from the body to ensure there was no cross-contamination and soiled linen should be bagged before leaving the a resident's room to prevent the spread of disease. The DON stated glove changes and hand hygiene should be performed after completing urinary catheter care to prevent cross contamination and spread of disease.

The facility policy Coronavirus (COVID-19) revised date 1/25/21, directed all recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, (i.e., goggles, and gown (if facility supplies allow).

The facility policy Handwashing, dated 11/19, directed hand hygiene was to be completed after changing incontinent products or cleaning up after someone who has used the toilet, after touching garbage, and before donning gloves, and after there removal of gloves.

The facility policy Laundry and Bedding, Soiled revised date 10/18, directed to handle all used laundry as potentially contaminated until it is properly bagged and labeled for appropriate processing. The policy further directed all contaminated laundry bags/containers are not to be held close to the body or squeezed during transport.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 12, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: DWRM11

Dear Administrator:

The above facility was surveyed on February 22, 2021 through February 25, 2021 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:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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 _____	C 02/25/2021

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 2/22/21, through 2/25/21, surveyors of this Department's staff visited the above provider and the following correction orders are issued. In addition, the following complaints were investigated: The following complaints were found to be	2 000		

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 _____	C 02/25/2021

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	Continued From page 1 UNSUBSTANTIATED: H5471018C H5471019C H5471020C H5471021C 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 14-01, available at 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. PLEASE DISREGARD THE HEADING OF THE	2 000		

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 _____	C 02/25/2021

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	Continued From page 2 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.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the opportunity to participate in the care planning process and be included in decisions about care, treatment and/or interventions in the required time frame for 1 of 1 resident (R27) reviewed for care conferences. Findings include: R27's Transfer/Discharge Report printed 2/25/21, indicated R27 was admitted to the facility on	2 570	F 553 Right to Participate in Planning Care Immediate Corrective Action: Resident #27□s care conference was scheduled to ensure that any issues were addressed and to review current care plan with resident and family. Corrective Action as it applies to others: The social services director will be educated on the need to complete care conferences after admission, quarterly, and with any change in condition.	3/29/21

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 _____	C 02/25/2021

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
2 570	Continued From page 3 11/11/20, with diagnoses that included cerebral infarction (stroke), atrial fibrillation, hypothyroidism, and palliative care. R27's significant change Minimum Data Set (MDS) dated 1/13/21, indicted R27 had severe cognitive impairment, and it was very important to R27 to have family involved in discussions about R27's care. On 2/22/21, at 5:36 p.m. an interview was conducted with family member (FM)-A. During the interview, FM-A stated she had a few concerns regarding R27's plan of care. FM-A stated R27's last care conference was when R27 was admitted. FM-A stated she had not received a called or received any information regarding any upcoming care conference dates for R27. On 2/25/21, at 10:17 a.m. an interview was conducted with the social service designee (SSD)-A. SSD-A stated care conferences were completed after admission, quarterly, and with a significant change in condition. SSD-A stated R27's last care conference was on 11/25/20, at 1:00 p.m. for R27's admission care conference. SSD-A stated R27 had a significant change in condition and an MDS was completed on 1/13/21. SSD-A verified R27 did not have a care conference with R27's change in condition, and R27's care conference was not on February's care conference schedule. The SSD-A stated R27 should have had a care conference when R27 had a change in condition. On 2/25/21, 1:17 p.m. an interview was conducted with the director of nursing (DON). The DON stated care conferences were held after admission, quarterly, and when a significant change in a resident's condition had occurred.	2 570	All residents will be reviewed to ensure that they are up to date on their required care conferences. Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of 5 residents care conference schedule will be conducted weekly x 4 and then monthly x 2 months to ensure that they received their appropriate care conference. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator Designee/Designee	

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 _____	C 02/25/2021

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
2 570	Continued From page 4 The DON stated SSD-A scheduled the care conferences and informed residents and/or resident representatives when care conferences were scheduled. The facility policy on Care Conferences was requested and not received. SUGGESTED METHOD OF CORRECTION: The social worker or designee could review and revise procedure with care conference scheduling and participation of residents and/or representative in planning of care. The social worker/designee could coordinate with interdisciplinary team and resident and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 570		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	2 910		3/29/21

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 _____	C 02/25/2021

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
2 910	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a comprehensive bladder and bowel assessment had been completed for 1 of 2 residents (R14) reviewed for bowel and urinary incontinence. Findings include: R14's Face Sheet printed 2/25/21, indicated diagnoses of benign prostatic hyperplasia (prostate gland enlargement) without lower urinary tract symptoms, hemiplegia and hemiparesis following cerebral infarction (stroke) affecting left side, urinary tract infections, and vascular dementia with behavioral disturbance. R14's annual Minimum Data Set (MDS) dated 9/22/20, indicated R14 was cognitively intact, and was extensively dependant on staff for toileting needs, did not have a toileting plan, and was always incontinent of bowel and bladder. R14's Quarterly MDS dated 12/15/20, indicated R14 had a indwelling urinary catheter, and was still incontinent of bowel. R14 was still assessed as being cognitively intact and needing the same level of toileting assistance as R14's prior annual MDS documented. R14's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 10/02/20, indicated, "Incontinent of bowel and bladder. Has a history of [benign prostatic hyperplasia] and takes Flomax [medication used in treating an enlarged prostate] and Finasteride [medication used in treating an enlarged	2 910	F 690 Bowel/Bladder Incontinence Immediate Corrective Action: Resident #14 had a comprehensive bowel and bladder assessment completed and care plan/NAR care sheet was updated to reflect toileting schedule. Corrective Action as it applies to others: The Behavior Programs and Toileting Plans for Urinary Incontinence Policy was reviewed and remained current. DON and NM were educated on need to complete a comprehensive bowel and bladder assessment for any annual or change in condition and to update care plan/NAR care sheets with results. All residents will be reviewed to ensure that they have had a timely bowel and bladder assessment and care plan/NAR care sheets with results. Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of 5 residents will be conducted weekly x 4 and then monthly x 2 months to ensure that a comprehensive bowel and bladder assessment has been completed annually and with any significant change and care plan/NAR care sheets have been updated. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/NM/Designee	

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 _____	C 02/25/2021

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
2 910	Continued From page 6 prostate]. Staff offer urinal every 2 hours and as needed. He doesn't ask staff to assist with toileting, unsure if he is aware of his need to void. He is on a check and change schedule with offering the urinal if dry." On 2/22/21, at 5:30 p.m. R14 was observed sitting in bed eating the evening meal he requested. R14 was noted to be sitting on a light yellow disposable soaker (incontinent) pad. On 2/22/21, at 6:15 p.m. R14 was interviewed and stated staff help him with urinal placement. R14 stated the nursing assistants check on him, and he also will place on his call light if he feels the urge to have a bowel movement or urinate. R14 also stated there are times "it just happens." R14 stated that he has issues with bladder infections as well. R14's MHM Bladder Evaluation (assessment) dated 9/22/20, documented only that R14 was incontinent of bladder, his diagnoses, and medications potentially effecting R14's incontinence. The assessment lacked a comprehensive determination on whether R14 had the potential for reversing/reducing urinary incontinence, did not identify the type of urinary incontinence, lacked documentation that a visual inspection of urethral area was performed, lacked determination of an individual treatment plan, nor was there any form of clinical summary to this assessment. R14's care plan last reviewed 2/22/21, indicated that the section on R14's bladder needs was last updated on 2/14/2019. The care plan indicated the following: "The resident has FUNCTIONAL bladder incontinence [related to] immobility and a diagnosis of [benign prostatic hyperplasia]. Goal:	2 910		

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 _____	C 02/25/2021

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
2 910	Continued From page 7	2 910		

The resident will be continent at all times though the review date.
Interventions/Tasks:
- Clean peri-area with each incontinence episode
- Continent unless sleeping, check and change at night every 2 hours. Will asked to be toileted. Assist of 1 for urinal, assist of 2 for commode.
- Ensure the resident has unobstructed path to the bathroom
- Establish voiding pattern
- provide medications per MD orders."

R14's incontinence tracking sheets used by the nursing assistants, documented the following:

2/22/21
Day Shift: 6 AM "X", 8 AM "X", 10 AM incontinent (INC) of bladder, 12 PM blank
Relief Shift: 2 PM small INC of both bowel and bladder, 4 PM blank, 6 PM blank, 8 PM blank
Night Shift: 10:30 PM INC of bladder, 12:30 AM continent, 2:30 AM INC bladder, 4:30 AM continent

2/23/21
Day Shift: 6-8 AM [did not void], 8-10 AM INC of bladder, 10 AM -12 PM "dry", 12 - 2 PM INC of bowel / bladder
Relief Shift: 2 - 4 PM moderate INC of both bowel and bladder, 4 - 6 PM INC of bladder, 6 - 8 PM "dry", 8 - 10 PM blank
Night Shift - 10:30 PM continent, 12:30 AM continent, 2:30 AM continent, 4:30 AM moderate INC of both bowel and bladder

2/24/21
Day Shift: 6-8 AM INC of bladder, 8-10 AM continent, 10 AM -12 PM continent, 12 - 2 PM continent
Relief Shift: 2 - 4 PM dry , 4 - 6 PM "adjusted for

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 _____	C 02/25/2021

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
2 910	Continued From page 8 supper", 6 - 8 PM large INC of both bowel and 8 - 10 PM blank Night Shift - 10 PM - 12 AM INC of urine, 12 - 2 AM continent, 2 - 4 AM continent, 4 - 6 AM INC bladder On 2/24/21, at 9:07 a.m. nursing assistant (NA)-A was interviewed and stated R14 was incontinent of bladder one to two times during a shift, sometimes with bowel. Referring to the care sheet posted at the nurses station, NA-A stated staff offer R14 toileting every two hours, but it may be during a two hour time frame (see documentation above). NA-A stated R14 did not always use his call light, and didn't know why. On 2/24/21, at 11:53 a.m. R14's family member (FM)-A was interviewed and stated R14 has been hospitalized for urinary tract infections over the last year. FM-A stated she did not think R14 was getting enough fluids, because he was on thicken liquids due to aspiration concerns. FM-A stated R14 complained about the taste and texture of thickened liquids. On 2/24/21, at 11:59 a.m. NA-B was interviewed and stated R14 was incontinent of bladder one to two times a shift, but usually only of urine. NA-B stated R14 did not place his call light on, and staff only know if he needed a urinal place or have a bowel movement when staff entered the room to offer. On 2/25/21, at 9:57 a.m. a nursing care manager (CM)-A was interviewed and stated in regards to both the bowel and bladder assessments not being completed for R14, nursing assistants indicating R14 was incontinent of urine one to two times a shift, and R14's care plan indicating R14 was "Continent unless sleeping," stated she	2 910		

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 _____	C 02/25/2021

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
2 910	Continued From page 9 would review R14's chart. The facility policy Behavior Programs and Toileting Plans for Urinary Incontinence revised 10/19, directed the purpose of the policy "..is to provide guidelines for the initiation and monitoring of behavioral interventions and/or a toileting plan for a resident with urinary incontinence." The policy had a procedure for assessment, which included monitoring voiding patterns, determining type of incontinence, if a resident is able to comprehend "education efforts and follow through with instructions", such as identification urinary and bowel urge. The policy identified how the facility would be able to assess a resident's ability (cognitive and physical) / willingness to be involved in a toileting plans and training, including "prompted voiding." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure comprehensive bowel and bladder assessments are completed. 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.	2 910		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing	2 920		3/29/21

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 _____	C 02/25/2021

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
2 920	Continued From page 10 home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to remove facial hair for 1 of 4 residents (R15) reviewed for assistance with activities of daily living (ADLs). Findings include: R15's Face Sheet printed 2/26/21, indicated R15's diagnoses included unspecified dementia. R15's quarterly Minimum Data Set (MDS) dated 12/15/20, indicated R15 was severely cognitively impaired. R15's care plan dated 10/4/19, indicated R15 required extensive assistance of one for all personal care. On 2/22/21, at 6:15 p.m. R15 was observed to have facial hair along the entire base of the chin that were approximately 1/8th of an inch long. A small area to the right of the chin had a cluster of 4-5 hairs that were approximately 1/4 inch long. On 2/23/21, at 1:20 p.m. R15's family member (FM)-A was interviewed. FM-A stated R15 was a beautician for many years, and "would be mortified" if she realized she had facial hair. On 2/24/21, at 7:29 a.m. was observed with eating breakfast. R15's facial hair remained	2 920	F 677 ADL Care Immediate Corrective Action: Resident #15□s facial hair was removed. Corrective Action as it applies to others: The policy for ADL Assistance per Care Plan Policy was reviewed and remained current. Nurses and CNAs will be educated on the need to provide facial hair removal per care plan/preference. All residents will be reviewed to ask about facial hair removal preferences and care plan/NAR care sheets will be updated. Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of 5 residents will be conducted weekly x 4 and then monthly x 2 months to ensure that they had facial hair removed per care plan/preference. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/Nurse Manager/Designee	

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 _____	C 02/25/2021

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
2 920	Continued From page 11 untrimmed. On 2/25/21, at 11:05 a.m. nursing assistant (NA)-G was interviewed. NA-G stated R15 had facial hair, and was not sure when they were last trimmed. NA-G stated facial hair was trimmed on shower days. The facility policy Monarch Healthcare ADL Assistance Per Care Plan revised 5/2018, directed "Based on resident/resident representative desires, assessment and care plan, ADL assistance will be provided to any residents deemed necessary. Some examples would be: Shaving (male and female) as needed." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure grooming, to shaving are provided for dependent residents. 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.	2 920		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services	21325		3/29/21

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 _____	C 02/25/2021

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
21325	Continued From page 12 include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental services were available for 1 of 1 residents (R5) reviewed for dental services. Findings include: R5's Face Sheet printed 2/25/21, indicated R5's diagnoses included idiopathic hydrocephalus, dementia, major depressive disorder, and Alzheimer's disease. R5's Minimum Data Set (MDS) dated 2/16/20, indicated R5 had moderately impaired cognition. On 1/3/21, at 11:07 a.m. a progress note indicated R5 was eating popcorn, when one of the front permanent teeth broke. The tooth was saved, R5's spouse was notified. On 1/5/21, at 12:55 p.m. a progress note indicated R5 had complaints of pain related to the broken tooth. A dental visit was being looked at. R5 had no difficulty eating. On 1/7/21, at 12:17 p.m. a progress note indicated a dental appointment was still in the works. R5 had not been having troubles with eating, and denied pain.	21325	F 791 Routine/Emergency Dental Services Immediate Corrective Action: Resident #5 had dental appointment set up. Corrective Action as it applies to others: The Availability of Services, Dental Policy was reviewed and remained current. Social Services Director was educated on need to assist with setting up dental services when needed. All residents were interviewed/assessed to see if they are in need of dental services and social services will ensure that they have dental appointment set up if requested/needed in a timely manner. Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of 5 residents will be conducted weekly x 4 and then monthly x 2 months to ensure that if they are in need of dental services that a dental appointment is being set up in a timely manner. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator Designee/Designee	

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 _____	C 02/25/2021

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
21325	Continued From page 13 R5's Oral/Dental Evaluation dated 2/15/21, at 5:40 p.m. indicated Summary/Interventions: "Has a new broken tooth, denies pain and a dental visit is being set up for him. No problems with eating." On 2/23/21, at 12:03 p.m. R5 was interviewed and stated his tooth has been broken since early January. R5 stated he "has not heard anything in weeks about dental appointment." R5 stated the tooth was not painful, but it had been bothersome and embarrassing because it was a front tooth, and"everyone can see it." On 2/24/21, 12:32 pm. R5's family member (FM)-B was interviewed and stated, " The nurses are working on getting [R5] to a dentist, [R5] needs to go to Ely. There is a dentist in Ely that will accept his insurance. There is no dentist in Two Harbors that will accept Medicaid insurance." FM-B stated it was not possible for her to transport R5 to the dentist. FM-B stated she did not know the status of the dental appointment or transportation, she has not heard back from facility. On 2/24/21, 11:25 p.m. case manager (CM)-A was interviewed and stated she did not know R5 had a dental issue. On 2/24/21, 1:57 p.m. social service (SS)-A was interviewed. SS-A stated area dentists refuse to accept all insurances, the dentist in Ely was one of a few who would accept R5's. SS-A stated finding transportation was also difficult. SS-A stated Ely was over an hour away, and transport companies will transport to Ely, but drivers will not wait for a resident. SS-A stated a health unit coordinator (HUC-B) had been working on setting up an appointment and arranging transportation, however, she had resigned the first week of	21325		

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 _____	C 02/25/2021

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
21325	Continued From page 14 February. The facility policy Availability of Services, Dental dated 8/07, directed "Dental services are available to all residents routine and emergency dental care." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents are provede with routine and emergency dental visits. 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.	21325		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper personal protection equipment (PPE) was donned (put on) before entering a resident's room on quarantine for 1 of 1 resident (R29) reviewed for	21375	F 880 Infection Control Immediate Corrective Action: Signage on resident #29□s room was updated to reflect current guidelines for PPE use. NAR responsible for the breach	3/29/21

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 _____	C 02/25/2021

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
21375	Continued From page 15 transmission-based precautions. In addition, the facility failed to ensure proper handling of soiled linen, and hand hygiene was performed during personal cares to prevent cross contamination for 1 of 4 residents (R39) reviewed for personal cares. Findings include: R29's Transfer/Discharge Report printed 2/25/21, indicated R29 diagnoses included congestive heart failure, and asthma. R29's admission Minimum Data Set (MDS) dated 1/26/21, indicated R29 was cognitively intact. R29's Discharge Instructions dated 2/22/21, indicated R29 was was hospitalized from 2/18/21, to 2/22/21, and returned to the care center on 2/22/21. On 2/24/21, at 10:56 a.m. physical therapist (PT)-A and occupational therapist (OT)-A were observed entering R29's room wearing eye protection and a surgical mask, and gloves. PT-A and OT-A did not put on an isolation gown prior to entering R29's room (R29 was on 14-day quarantine after his re-admission from a hospitalization). On 2/24/21, at 10:57 a.m. R29's door was observed to have a stop sign on the outside of R29's door and indicated R29 was on a 14-day quarantine/contact droplet precautions and directed: -Perform hand hygiene before entering and before leaving the room. -Wear gloves a when entering room, and when touching resident, surfaces, or articles in close	21375	in infection control during surveyor observation was immediately educated on appropriate process for handwashing, glove changes, and carrying soiled items out of room. Corrective Action as it applies to others: The Soiled Laundry and Bedding Policy was reviewed and remained current. All facility staff including therapy were educated on need to follow the signage on the doors regarding PPE use. Nurses and CNAs are being educated on the need to change gloves and wash hands in going between tasks before touching other items/areas as well as placing soiled items in a bag before leaving a room and throwing them in the appropriate receptacle. All resident rooms who are quarantine or isolation will be reviewed to ensure that the appropriate PPE signage is posted on the door. Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of all residents in isolation or quarantine will be conducted weekly x 4 and then monthly x 2 months to ensure that the appropriate signage is posted on the resident door and that staff entering are wearing appropriate PPE. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Audits of 5 residents will be conducted weekly x 4 and then monthly x 2 months to ensure that staff are changing gloves and washing hands in going between tasks before touching other items/areas as well as placing soiled items in a bag before	

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 _____	C 02/25/2021

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
21375	Continued From page 16	21375		

proximity.
-Wear mask when entering room.
-Wear gown whenever anticipating that clothing will be in contact with bodily secretions.
-Disinfect equipment after use. (blood pressure cuff [BP], thermometers etc).

On 2/24/21, at 10:59 a.m. registered nurse (RN)-C stated if physical contact with R29 was anticipated, a gown was to be worn along with eye protection, mask, and gloves. RN-C stated if staff were to go into R29's room for less than 15 minutes and had no physical contact with R29 or the environment, a gown was not needed.

On 2/24/21, at 11:05 a.m. nursing assistant (NA)-C knocked and opened R29's door. PT-A and OT-A were observed wearing gloves, eye protection, and a surgical mask. PT-A and OT-A were not wearing gowns and were assisting R29 to stand. NA-C verified he observed R29 in his wheelchair with the walker in front of R29, and PT-A and OT-A were assisting R29 to stand.

On 2/24/21, at 11:19 a.m. PT-A and OT-A exited R29 's room without wearing a gown or gloves and performed hand hygiene.

On 2/24/21, at 11:20 a.m. OT-A and PT-A stated they were working with R29 on endurance and strengthening after R29's returned from the hospital 2/22/21. PT-A stated she was able to get R29 up and out of bed today. OT-A and PT-A stated they were instructed by a director of nursing from another corporate facility, a gown was only needed when coming in contact with bodily fluids. PT-A and OT-A both stated they followed the signage on the resident's door in what PPE to wear. PT-A stated the sign on R29's door directed to wear a gown only when coming

leaving a room and throwing them in the appropriate receptacle. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.
Corrections will be monitored by:
DON/NM/Designee

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 _____	C 02/25/2021

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
21375	Continued From page 17 in contact with bodily secretions. On 2/24/21, at 1:58 p.m. speech therapist pathologist (SLP)-A stated eye protection, mask and gloves were to be worn before entering a resident's room on quarantine. SLP-A stated a gown was only needed if coming into contact with a resident's bodily fluids. SLP-A stated she was educated on proper PPE by a DON at another corporate facility. On, 2/24/21, at 1:59 p.m. housekeeper (H)-A stated when cleaning a quarantine room a gown was not needed since she was not touching a resident. H-A stated only eye protection, gloves, and a mask were needed. On 2/24/21, at 2:07 p.m. RN-B stated before entering a quarantine room eye protection, a mask, gloves, and a gown were needed. RN-B observed the signage outside R29's door and verified the it was incorrect. RN-B stated putting on a gown was required when coming in close contact with R29. RN-B further stated she would remove the sign and print the correct signage for R29's door. RN-B stated the language in the sign was from anther Monarch facility which had been low on PPE. RN-B verified the facility was not low on PPE. On 2/24/21, 2:13 p.m. the director of therapy (PT)-B stated therapy staff were to follow the guidelines the facility had in place for the proper PPE use. R39's Transfer/Discharge Report printed 2/25/21, indicated R39's diagnoses included acute kidney failure, and wedge compression fracture of the fourth lumbar vertebra.	21375		

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 _____	C 02/25/2021

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
21375	Continued From page 18	21375		

R39's admission MDS dated 2/8/21, indicated R39 had moderately impaired cognition and was dependent on staff for toileting and personal hygiene. R39's MDS further indicated he had an indwelling catheter.

On 2/24/21, at 7:39 a.m. during observations of personal cares, NA-H warmed up a wash cloth and handed it to R39 to wash his face. NA-H assisted R39's remove his pants and took a clean wash cloth and wiped and dried R39's perineal area and placed the soiled linens on R39's bed. NA-H disconnected R39's catheter tubing from the drainage bag , disinfected the urinary tubing with an alcohol pad, cleansed the tip of leg bag tubing and attached to the catheter. NA-H measured R39's urinary output from the drainage bag, placed the catheter drainage drainage bag in a basin and covered it with a towel. Wearing the soiled gloves, NA-A washed R39's bottom, assisted him to dress, and placed the soiled towels on an extra bed in R39's room. NA-A removed their soiled gloves, did not perform hand hygiene, put on a clean pair of gloves, and assisted R39 into a recliner chair. NA-H made R39's bed, picked up R39's cell phone, plugged it into a charger, placed a tray table in front of R39, and handed R39 his hearing aides. NA-H removed a garbage bag from the garbage can, and put in a new bag. NA-H picked up the dirty linens from the other bed, held them against his chest and arm, and exited R39's room. NA-H carried the bundle of soiled linens down the hallway without bagging, dropped a towel on the hallway floor, and carried the soiled linens to the shower room and placed in the hamper. NA-H then washed hands.

On 2/24/21, at 8:02 a.m. NA-H stated soiled linens should be placed in a plastic bag before

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 _____	C 02/25/2021

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
21375	Continued From page 19	21375		

leaving a residents room to prevent the spread of infection and dropping linens. NA-H stated soiled linens should be held away from the body to avoid contaminating clothing. NA-H stated gloves should be changed after providing catheter care. NA-H stated hand hygiene should be performed before putting on gloves, after the removal of gloves, and after leaving the resident's room.

On 2/25/21, at 2:32 p.m. the director of nursing (DON) stated staff were expected to wear eye protection, a surgical mask, gloves, and an isolation gown before entering a quarantine room. The DON stated therapy staff were expected to wear a gown in addition to the rest of the PPE as therapists often had direct contact with the residents. The DON stated this increased the risk for contaminating clothing and the potential to spread infection to others. The DON stated soiled linen should be handled away from the body to ensure there was no cross-contamination and soiled linen should be bagged before leaving the a resident's room to prevent the spread of disease. The DON stated glove changes and hand hygiene should be performed after completing urinary catheter care to prevent cross contamination and spread of disease.

The facility policy Coronavirus (COVID-19) revised date 1/25/21, directed all recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, (i.e., goggles, and gown (if facility supplies allow).

The facility policy Handwashing, dated 11/19, directed hand hygiene was to be completed after changing incontinent products or cleaning up

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 _____	C 02/25/2021

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
21375	Continued From page 20 after someone who has used the toilet, after touching garbage, and before donning gloves, and after there removal of gloves. The facility policy Laundry and Bedding, Soiled revised date 10/18, directed to handle all used laundry as potentially contaminated until it is properly bagged and labeled for appropriate processing. The policy further directed all contaminated laundry bags/containers are not to be held close to the body or squeezed during transport. Suggested Method of Correction: The Director of Nursing (DON) or designee could review and revise policies and procedures related infection control practices including the use of PPE, hand hygiene, and proper handling of soiled lines. The DON or designee could educate staff and perform audits to ensure the policies are being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the	21435		3/29/21

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 _____	C 02/25/2021

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
21435	Continued From page 21 planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure meaningful activities of were provided to 1 of 1 residents (R27) reviewed for activities. Findings include: R27's Transfer/Discharge Report printed 2/25/21, indicated R27 diagnoses included cerebral infarction (stroke) and palliative care. R27's significant change Minimum Data Set (MDS) dated 1/13/21, indicted R27's family and religious activities were very important to R27. The MDS further indicated R27 was totally dependent on staff for bed mobility, transfers, dressing, grooming, eating, toileting, and personal hygiene. R27's Therapeutic Recreation Evaluation dated 11/13/20, indicated R1 had clear speech, was very religious, enjoyed Polka and old county music, TV land and ME TV, required frequent or continual prompts/cueing to engage in group process, and program plan was to attend small groups and church. R27's care plan dated 1/7/21, indicated R27 wishes were to be invited and assisted to group programs of interest such as church services. R27's Care Area Assessment (CAA) for cognition loss/dementia dated 1/26/21, identified R21 exhibited short and long-term memory problems	21435	F 679 Activities Meet Interest Immediate Corrective Action: Resident #27 and family was interviewed to determine activity preferences to integrate with resident□s care plan. Corrective Action as it applies to others: The Activity Evaluation Policy was reviewed and remained current. Activity Director and activity staff will be educated on need to interview resident/family regarding activity preferences and to integrate them into the resident care plan and to provide activities that are meaningful to the resident. All residents/families will be interviewed regarding activity preferences and these preferences will be integrated into the resident care plan. Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of 5 residents will be conducted weekly x 4 and then monthly x 2 months to ensure that care plan has been updated on activity preferences and are being provided meaningful activities. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator/Social Services/Designee	

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 _____	C 02/25/2021

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
21435	Continued From page 22	21435		

and staff need to anticipate R21's wants and needs.

A nursing assistant care guide dated 2/22/21, lacked indication of R27's preference to attend church services on Wednesdays.

On 2/22/21, at 5:23 p.m. family member (FM)-A stated she was unsure what activities were being offered to R27. FM-A stated R27 was a devoted Catholic and was very religious. FM-A stated she requested for staff to bring R27 to church services on Wednesdays. FM-A stated she would like to see R27 get out of her room a more often and have more human interactions even if it was once a week to go to church.

During observations on 2/23/21, at 9:06 a.m. R27 was in was in bed with the lights off and curtain drawn. No music or television was on.

During observations on 2/24/21, at 7:09 a.m. R27 was in bed, the lights were off, and the curtain was drawn. At 8:57 a.m. nursing assistant (NA)-H entered R27's room and offered R27 something to drink. R27 declined. R27 remained lying on her back wearing a hospital gown. At 9:15 a.m. R27 was in bed lying on her back. No television or music was on. At 10:25 a.m. R27 was in bed, and the church service was scheduled to begin at 10:30 a.m. No staff offered to bring R27 to church service.

During observations on 2/25/21, at 8:49 a.m. R27 was in bed wearing a hospital gown and no television or music was on.

On 2/24/21, at 10:36 a.m. FM-B stated when she visited R27, R27 was usually in bed. FM-B stated it would mean a lot to R27 if R27 were to

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 _____	C 02/25/2021

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
21435	Continued From page 23	21435		

be able to get dressed and brought to church services on Wednesdays. FM-B stated R27 was very spiritual, a devoted catholic, and always wore a dress.

On 2/24/21, at 1:48 p.m. NA-H confirmed she did not ask R27 if she wanted to attend Wednesday church services and further stated she had not seen R27 attend any church service since R27 was admitted. NA-H stated R27 preferred to stay in bed and when offered to get up, R27 refused.

On 2/24/21, at 1:45 p.m. NA-C confirmed R27 did not get out of bed for lunch and was not offered to attend Wednesday church services. NA-C stated R27 would refuse to get up in her chair when offered and preferred to stay in bed. NA-C stated R27 moaned, yelled out, and would complain of pain.

On 2/25/21, at 9:38 a.m. activity director (AD)-A stated activity assessments were completed on admission. AD-A stated one-on-one activities were provided to residents that were unable to attend regular group activities. AD-A stated R27's one-on-one activities included reading books, music, talking, and holding hands. AD-A stated one-on-one visits were not scheduled and she tried to see R27 once weekly for activities. AD-A stated R27 was Catholic and tried to have someone come in monthly to give R27 communion. AD-A stated she had not seen R27 attend Wednesday church services and was unaware if staff were asking R27 if she would like to attend. AD-A stated R27 was on hospice and preferred to stay in her bed. AD-A stated she was aware religious services were very important to R27, and confirmed R27 should be given an opportunity to attend.

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 _____	C 02/25/2021

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
21435	Continued From page 24	21435		

R27's Follow Up Question Report dated 12/27/20 to 2/25/21, indicted the following:
-On 12/20/20, during Religious Service/Bible Study/Prayer activity, R27 passively participated.
-On 1/6/21, during Religious Service/Bible Study/Prayer activity, R27 was not available.
-On 1/20/21, during Religious Service/Bible Study/Prayer activity, R27 was not available.
-On 1/27/21, during Religious Service/Bible Study/Prayer activity, R27 was not available.
-On 2/3/21, during Religious Service/Bible Study/Prayer activity, R27 refused.
-On 2/10/21, during Religious Service/Bible Study/Prayer activity, R27 was not available.
-On 2/19/21, during Religious Service/Bible Study/Prayer activity, R27 was not available.
-On 2/24/21, during Religious Service/Bible Study/Prayer activity, R27 was not available contrary to observation.

On 2/25/21, at 1:21 p.m. AD-A stated documentation of "Not Available" could mean R27 was sleeping or had a visitor. AD-A stated the activity charting system only allowed for selected answers to be chosen from. AD-A confirmed an activity participation selection included "Family/Friend/Visit in the Facility." The AD-A verified, according to R27's Follow Up Question Report dated 12/29/20 to 2/25/21, the majority of R27's activity participation for Religious Service/Bible Study/ Prayer was documented "Resident not available".

On 2/25/21, at 1:17 p.m. the director of nursing (DON) stated if a resident refused cares, services, or treatments, staff were expected to report the refusal to the nurse. The DON stated staff were expected to re-approach a resident and document the refusal, and along with interventions tried, in the medical record. The

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 _____	C 02/25/2021

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
21435	Continued From page 25 DON stated if a resident's meaningful activity was to attend church she would expect staff to offer the resident an opportunity to attend church. Facility policy titled Activity Evaluation undated, directed an activity evaluation is conducted as part of the comprehensive assessment to help develop an activity plan that reflects the choices and interests of the resident. The policy further directed the resident's lifelong interests, spirituality, life roles, goals, strength, needs and activity pursuit patterns and preferences are included in the evaluation. The completed activity evaluation is updated as necessary but at least quarterly. SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and or revise policies and procedures to ensure all residents are invited to attend activities according to their comprehensive activity assessment for individualized meaningful activities. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
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	21545		3/29/21

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 _____	C 02/25/2021

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
21545	Continued From page 26	21545		

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 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:

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 _____	C 02/25/2021

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
21545	Continued From page 27 Based on observation, interview, and document review, the facility failed to ensure medications were not crush and mixed together (cocktail) or administered together without physician orders and evaluation, to prevent adverse interactions for 3 of 6 residents (R31, R36, R28) reviewed for medication administration. Findings include: R31's Transfer/Discharge Report dated 2/24/21, indicated R31's diagnoses included dementia without behavioral disturbance, myasthenia gravis (a disease that causes weakness in voluntary muscles, such as muscles for swallowing), and thoracic spinal pain. R31's Order Summary Report for active orders as of 2/24/21, included orders for: -Tylenol 325 milligrams (mg); give 2 tablets by mouth 4 times a day - Pyridostigmine Bromide (to decrease weakening of muscles with myasthenia gravis) tablet; give 60 mg by mouth 3 times a day -Ibuprofen Tablet 400 mg by mouth 3 times a day for left foot pain for 14 days -Gabapentin 300 mg by mouth 2 times a day and 600 mg at bedtime related to pain in thoracic spine -regular diet, mechanical soft texture, regular (thin) consistency (liquids), pureed diet, OK for regular texture at breakfast. R31's Order Summary Report lacked indication to crush or cocktail medications. R31's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for 2/21, lacked direction to crush and cocktail medications.	21545	F 759 Free of Medication Error >5% Immediate Corrective Action: Nurse involved was immediately educated on that cocktailing of meds is not appropriate unless there is a specific MD order. Corrective Action as it applies to others: The Administering Medications through an Enteral Tube Policy was reviewed and remained current. All nurses/TMAs were educated that cocktailing (mixing) of medications is not appropriate for residents who have a tube feeding unless there is an MD order. Also, educated that medications can□t be crushed and mixed together unless there is an MD order. All residents who receive medications via feeding tube or require crushed medications will have MD notified to determine whether crushing and/or mixing of medications is appropriate for that resident. Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of 5 residents will be conducted weekly x 4 and then monthly x 2 months to ensure that any resident who receives crushed medications or medications through a PEG tube are administered individually unless there is an MD order that it is ok to mix and administer together. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/NM/Designee	

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 _____	C 02/25/2021

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
21545	Continued From page 28	21545		

On 2/22/21, at 5:57 p.m. licensed practical nurse (LPN)-B was observed preparing R31's medications for administration. Medications included Tylenol, Pyridostigmine, Motrin, and gabapentin. LPN-B put Tylenol, Pyridostigmine and Motrin into a small plastic bag, and crushed them together. LPN-B stated R31 should have an order for crushing medications in the TAR, and said she could not pull up the orders on her computer. LPN-B stated R31 was on a pureed diet, so it was OK to crush her medications together. LPN-B continued to crush the medications together, mixed them with apple sauce, and added the uncrushed gabapentin capsule into the apple sauce. LPN-B then administered the medications to R31, and after persuading, R31 took her medications as prepared.

R36's Transfer/Discharge Report dated 2/24/21, indicated R36's diagnoses included Alzheimer's disease, congestive heart failure, atrial fibrillation (irregular heart rhythm), moderate protein-calorie malnutrition, and dysphagia (swallowing difficulties).

R36's Order Summary Report for active orders as of 2/24/21, included orders for:
-donepezil; give 10 mg by mouth at bedtime related to Alzheimer's disease
-metoprolol succinate extended release (ER) 24 hour; give 25 mg by mouth every morning and at bedtime related to congestive heart failure
-mirtazapine tablet; give 15 mg by mouth at bedtime related to moderate protein-calorie malnutrition.
-regular diet, puree meat texture, honey consistency liquids.
-medications crushed to pureed consistency every shift related to dysphagia. R31's order

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 _____	C 02/25/2021

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
21545	Continued From page 29	21545		

lacked directives to cocktail crushed medications together, and which medications could be crushed.

R36's MAR for 2/21, directed to crush medications to pureed consistency every shift related to dysphagia. R36's MAR lacked directions to cocktail crushed medications together and which medications could be crushed.

On 2/22/21, at 6:37 p.m. LPN-C was observed preparing R36's medications for administration, including donepezil, metoprolol succinate ER, and mirtazapine. LPN-C put the medications into a small plastic bag and crushed them together. LPN-C verified R36 had orders for crushing medications on the MAR. LPN-C stated directives could not be on the MAR without an order, and verified R36 did not have orders to crush medications together. LPN-C put the crushed medications in applesauce and administered the medications to R36.

R28's Transfer/Discharge Report dated 2/24/21, indicated R28's diagnoses included osteoporosis, atherosclerotic heart disease (ASHD- hardening and narrowing of your arteries), heart failure, major depressive disorder, chronic pain, vitamin D deficiency, constipation, and gastro-esophageal reflux disease (GERD-when stomach acid frequently flows back into the tube connecting the mouth and stomach).

R28's Order Summary Report for active orders as of 2/24/21, included orders for:
-aspirin tablet chewable; give 81 mg in the morning related to chronic atrial fibrillation
-calcium carbonate tablet 600 mg; give 600 mg in the morning related to age-related osteoporosis

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 _____	C 02/25/2021

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
21545	Continued From page 30	21545		

-cholecalciferol capsule give 1000 units in the morning related to age-related osteoporosis
-isosorbide mononitrate tablet; give 30 mg every morning and at bedtime related to ASHD
-Lipitor tablet 40 mg; give 40 mg in the morning related to hyperlipidemia
-multivitamin adult tablet; give one table in the morning for supplement
-Norco tablet 5-325 mg; give 1 tablet every morning and at bedtime for chronic back pain
-Norvasc; give 5 mg in the morning related to essential hypertension
-Protonix Tablet delayed release 40 mg; give one tablet in the morning for dissolve and mix in one tsp apple juice related to GERD
-Senna-S Tablet 8.6-50 mg; give one tablet in the morning for constipation
-Zoloft Tablet; give 100 mg in the morning related to major depressive disorder
-NPO diet (nothing by mouth)
-Medications have to be given one at a time through PEG tube (percutaneous endoscopic gastrostomy tube place directly into the stomach for enteral feeding, hydration and medication administration) with small water flushes in between. DO NOT ADMINISTER MEDICATIONS TOGETHER, order date 4/6/20.

R28's MAR for 2/21, directed to give medications one at a time through the PEG tube with small water flushes in between. DO NOT ADMINISTER MEDICATIONS TOGETHER.

On 2/24/21, at 7:38 a.m. registered nurse (RN)-A was observed preparing R28's medications for administration. RN-A dispensed the medications into two medication cups together, and started to take a plastic bag to put them into for crushing. When asked if medications were to be crushed together, RN-A stopped and said she should

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 _____	C 02/25/2021

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
21545	Continued From page 31	21545		

probably do one at a time, but said she usually crushed and gave them together. RN-A stated she found the orders to do one medication at a time and proceeded to crush each medication individually and put them in separate medication cups. RN-A brought the crushed medications to R28's room, and after checking R28's PEG tube for residual and flushing the tube with a small amount of water, put approximately 5 to 10 milliliters (ml) into each medication cup and mixed the medications in the water. RN-A poured the medications from each cup into R28's PEG tube one right after another without flushing between each medication. RN-A stated R28 did not have orders to flush between each medication, but her orders said to give one at a time.

On 2/24/21, at 2:45 p.m. the director of nursing (DON) was interviewed and stated R28's medications should be crushed individually and administered individually, and verified R28's MAR directed to give each medication individually separated by water. The DON stated they follow medication orders when residents are admitted from the hospital, if it says do not crush, and put it on the MAR. The DON stated otherwise it was nursing judgement, as they have it on their standing orders. The DON stated they get an order from the physician to crush medications. The DON also stated the pharmacist reviewed medications and indicated if they need to be separated.

On 2/25/21, at 12:10 p.m. the consultant pharmacist (CP)-A stated medications should not be co-mingled when crushed, because you just don't know what kind of interactions they may have. CP-A stated the nursing staff should get an order to crush and have the pharmacist review for

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 _____	C 02/25/2021

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
21545	Continued From page 32	21545		

crushing and cocktailing crushed medications. CP-A stated they should not be crushing extended-release medication, as they would not get the proper effect from the medication. CP-A stated they have reviewed R28's medications to be crushed, and verified they should be administered separately and have a water flush between each medication. CP-A stated he had not reviewed other residents for crushing medications, and reviewed R31 and R36's medication observed to be crushed at this time. CP-A stated he would review their medications for crushing.

The facility policy Crushing Medications revised 4/18, directed the medical director, DON and CP would identify appropriate indications and procedures for crushing medications, and directed nursing or CP to notify the ordering physician to crush a medication when the manufacturer advised a medication should not be crushed, such as long-acting or enteric coated medication. The policy directed the physician or CP must identify an alternative medication and/or dosage form, document why crushing medications will not adversely affect the resident, provide justification why the dosage form modification will not compromise the resident, and the nursing staff will observe the resident for pertinent adverse effects. The MAR must indicate why it is necessary to crush medications. The policy further directed medications should be crushed separately and administered with food, and addressed that sometimes giving them separately may not be appropriate for a resident.

The facility policy Administering Medications through an Enteral Tube revised 11/18, directed nursing to administer each medication separately and flush between medications, and ensure

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 _____	C 02/25/2021

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
21545	Continued From page 33 medications are not on the "Do Not Crush Medication List" with the pharmacy. The policy further directed to flush with 15 ml water between medications. Suggested Method of Correction: The director of nursing (DON) or designee could ensure all staff responsible for administering medications were re-educated. The DON or designee could observe medication administration to ensure staff are administering medications according to physician's orders and manufacturer's instructions unless otherwise specified by the physician. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper labeling on medications for 1 of 6 residents (R28) reviewed for medication administration. Findings include: R28's Transfer/Discharge Report dated 2/24/21, indicated R28's diagnoses included osteoporosis, atherosclerotic heart disease (ASHD- hardening and narrowing of your arteries), heart failure, major depressive disorder, chronic pain, vitamin	21620	F 761 Label/Store Drugs and Biologicals Immediate Corrective Action: Resident #28□s medication card was updated to reflect the current dosage/instructions. Corrective Action as it applies to others: The Labeling of Medications Policy was reviewed and remained current. All nurses/TMAs were educated on the need to ensure that their medication cards match the order before administering the medication(s).	3/29/21

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 _____	C 02/25/2021

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
21620	Continued From page 34 D deficiency, constipation, and gastro-esophageal reflux disease (GERD-when stomach acid frequently flows back into the tube connecting the mouth and stomach). R28's Order Summary Report for active orders as of 2/24/21, included orders for: -calcium carbonate tablet 600 mg; give 600 mg in the morning related to age-related osteoporosis, order date 4/6/20. -Norco tablet 5-325 mg; give 1 tablet every morning and at bedtime for chronic back pain, order date 4/6/20. -Medications have to be given one at a time through PEG tube (percutaneous endoscopic gastrostomy tube place directly into the stomach for enteral feeding, hydration and medication administration) with small water flushes in between. DO NOT ADMINISTER MEDICATIONS TOGETHER, order date 4/6/20. On 2/24/21, at 7:38 a.m. registered nurse (RN)-A was observed preparing R28's medications for administration. RN-A prepared medications to administer to R28. RN-A dispensed one 500 milligram (mg) tablet of Oyster Shell Calcium into a medication cup. RN-A read the label and compared it with the Medication Administration Record (MAR) and stated R28's MAR stated R28 was to receive one 600 mg tablet of calcium, but the pharmacy sent the 500 mg tablets. RN-A said she would call the physician to notify them that the resident received the wrong medication dosage. When asked what she would do when the label did not match the orders, she said they put stickers on the medication to alert nursing to check the medication orders. RN-A stated she would call the pharmacy, also. R28's medication bottle indicated R28's bottle of calcium had been sent from the pharmacy on 2/20/21, and had	21620	All residents medication cards will be reviewed to ensure that medication cards match the current orders. If they don t match, a sticker will be placed on the card to notify nurse/TMA of a medication change and to check chart and pharmacy will be updated. Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of 5 residents will be conducted weekly x 4 and then monthly x 2 months to ensure that the medication cards match the current orders. The results will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/NM/Designee	

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 _____	C 02/25/2021

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
21620	Continued From page 35 contained 30 tablets. RN-A counted the remaining tablets, and indicated 27 had remained after she had dispensed one, indicating 2 tablets of the wrong dose had been previously administered. RN-A stated she would give the 500 mg tablet, since it was less than the prescribed dose, and then notify the physician. In addition, R28's Norco 5-325 mg label read to administer one tablet twice daily as needed for pain. R28's orders indicated R28's Norco was scheduled for twice daily. RN-A stated R28 had received new orders. On 2/24/21, at 2:45 p.m. the director of nursing (DON) verified medication labels should match the orders, and the pharmacy should be notified if they did not match. The facility policy Labeling of Medications dated 12/19, directed all medications in the facility would be properly labeled in accordance with the current state and federal regulations, and nursing would inform the pharmacy of any changes in physician orders for a medication. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents' medications are labeled with an appropriate pharmacy labeled. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		

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 _____	**02/24/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW SHORES LLC	**402 - 13TH AVENUE** **TWO HARBORS, MN 55616**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/22/2021

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.

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 _____	**02/24/2021**

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 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Waterview Shores LLC is a 1-story building that was constructed in 1979 with a partial basement, that was determined to be of Type II(111) Construction. In 1998 a one-story addition with no basement was constructed that was determined to be of Type II(111). In 2001 a kitchen addition was constructed and was determined to be of Type II(111). The facility has 3 separate smoke compartments; and in 2001, an assisted living building was added, that is properly 2 hour rated separated from the nursing home. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with	K 000		

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 _____	**02/24/2021**

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 smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 44 beds and had a census of 33 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not maintained the fire alarm system testing and maintenance documentation in accordance with NFPA 72 National Fire Alarm Code 2010 edition 14.6.2. This deficient condition could negatively affect 44 of 44 residents. Findings include: On 02/24/2021, at 11:59 a.m. during a review of all available fire alarm maintenance and testing documentation for the last 12 months, and an	K 345	K345 Fire Alarm System Testing and Maintenance Corrective action taken: Contracted life safety inspection provider will provide facility a new form which itemizes inspected devices in order to meet compliance with life safety code guidelines. Corrective action taken to address similar issues (if necessary): Maintenance Director, Maintenance Assistant, and Administrator will be educated on the	4/11/21

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 _____	**02/24/2021**

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 345	Continued From page 3 interview with the Maintenance Supervisor, it was revealed that at the time of the inspection the facility had completed the annual fire alarm system testing; but upon further review of the annual fire alarm testing documentation it was found that the inspection report did not contain a detailed list of all the individual initiating devices that had been tested and the results of the testing completed on each individual device. This deficient condition was verified by the Maintenance Supervisor.	K 345	need for all initiating devices to be itemized in annual inspections. Date of compliance: 4/11/21 Recurrence prevented by: Maintenance Director will ensure that the itemization of devices is included as part of the annual inspection report. Corrections monitored: Monitored by the Maintenance and Administrator of Record	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the	K 351	K351 Fire Sprinkler Installation	4/11/21

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 _____	**02/24/2021**

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 351	Continued From page 4 automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 2010 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (10) could allow the system to be placed out of service, causing a decrease in the fire protection system capability in the event of an emergency that could affect 44 of 44 residents. Findings include: 1. On 02/24/2021, at 12:27 p.m. during the facility tour, it was observed that the facility had failed to remove a dry pipe system sprinkler head that is located within 36 inches of a wet pipe system sprinkler head in the corridor outside of the entrance to the staff support corridor doors. 2. On 02/24/2021, at 1:00 p.m. during the facility tour, it was observed that the facility had failed to remove a dry pipe system sprinkler head that is located within 36 inches of a wet pipe system sprinkler head in resident room 106 bathroom located in the west wing of the facility. 3. On 02/24/2021, at 1:05 p.m. during the facility tour, it was observed that the facility had failed to remove a dry pipe system sprinkler head that is located within 36 inches of a wet pipe system sprinkler head in the corridor outside of resident room 104 in the west wing of the facility. 4. On 02/24/2021, at 1:15 p.m. during the facility tour, it was observed that the facility had failed to remove a dry pipe system sprinkler head that is located within 36 inches of a wet pipe system sprinkler head in the west wing med storage	K 351	Corrective action taken: Facility is in process of receiving bids to contract removal of dry pipe sprinkler system heads throughout the facility. Corrective action taken to address similar issues (if necessary): Maintenance Director, Maintenance Assistant, and Administrator will be educated on the need for all fire sprinkler systems no longer in use to be removed. Date of compliance: 4/11/21 Recurrence prevented by: Maintenance Director will ensure that all sprinkler systems are maintained according to state and federal law and will ensure that sprinkler systems no longer in use are removed. Corrections monitored: Corrections will be monitored by Maintenance Director and Administrator of Record	

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 _____	**02/24/2021**

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 351	Continued From page 5 room. 5. On 02/24/2021, at 1:37 p.m. during the facility tour, it was observed that the facility had failed to remove a dry pipe system sprinkler head that is located within 36 inches of a wet pipe system sprinkler head that is located in the laundry room. These deficient conditions were verified by the Maintenance Supervisor.	K 351		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code	K 353	K353 Sprinkler System Maintenance and Testing	4/11/21

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 _____	**02/24/2021**

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 353	Continued From page 6 (NFPA 101) section 9.7.5 and NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, and 5.2.1.1.5, the standard for testing and maintenance of sprinkler systems. This deficient condition could affect 20 of the 44 residents. Findings include: 1. On 02/24/2021, at 1:50 p.m. during the facility tour, it was observed that the facility had several corroded fire sprinkler heads located in the kitchen around the cooking units and outside of the freezer and cooler units. 2. On 02/24/2021, at 1:57 p.m. during the facility tour, it was observed that the escutcheon ring was missing from the sprinkler head located in the dietary supervisor's office that is located in the kitchen. 3. On 02/24/2021, at 2:15 p.m. during the facility tour, it was observed that the facility had a fire sprinkler head located in the lower level storage room that had a bulb that was clear and appeared to not have any fluid within the bulb. This deficient condition was confirmed by the facility Maintenance Supervisor.	K 353	Corrective action taken: Facility is in process of receiving bids to contract replacement of damaged and non-compliant sprinkler heads throughout the facility. Corrective action taken to address similar issues (if necessary): Maintenance Director, Maintenance Assistant, and Administrator will be educated on the need for all sprinklers to be maintained up to state and federal compliance standards. Date of compliance: 4/11/21 Recurrence prevented by: Audits of sprinkler heads will be conducted monthly x 3 months. The results will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections monitored by: Corrections will be monitored by Maintenance Director and Administrator of Record	
K 363 SS=E	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	K 363		4/11/21

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 _____	**02/24/2021**

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 363	Continued From page 7 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 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 had 3 of numerous corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition, section 19.3.6.3 and 19.3.6.3.1. This deficient practice could affect 20	K 363	K363 Corridor Doors Corrective action taken: Facility completed a door audit to determine which doors needed modification or	

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 _____	**02/24/2021**

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 363	Continued From page 8 of 44 residents. Findings include: 1. On 02/24/2021, at 1:15 p.m. during the facility tour, it was observed that the corridor door to resident room 101 in the west wing of the facility was being propped open with a waste paper basket. 2. On 02/24/2021, at 1:15 p.m. during the facility tour, it was observed that the corridor door to resident room 105 in the west wing of the facility was being propped open with a waste paper basket. 3. On 02/24/2021, at 1:27 p.m. during the facility tour, it was observed that the corridor door to resident room 114 in the east wing of the facility did not positively latch into the door frame and had a gap of 1/2 of an inch between the door jam and the top of the latch side of the door. These deficient conditions were verified by the Maintenance Supervisor.	K 363	maintenance to allow them to remain open and in compliance as well as identify doors that need to be replaced. Corrective action taken to address similar issues (if necessary): Maintenance Director, Assistant Maintenance Director, and Administrator will be educated on the need for doors to meet fire code standards. Date of compliance: 4/11/21 Recurrence prevented by: Audits of doors will be conducted monthly x 3 months. The results will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Audit results will be used to inform decisions about doors that need to be replaced. Corrections monitored: Corrections will be monitored by Maintenance Director and Administrator of Record	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511		3/12/21

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 _____	**02/24/2021**

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 511	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain the required working spaces within 1 of 2 electrical / mechanical rooms in accordance with the NFPA 101 "The Life Safety Code" 2012 edition, section 9.1.2 and the NFPA 70 "National Electrical Code" 2011 edition, section 110.26. This deficient practice could affect 44 of 44 residents. Findings include: On 02/24/2021, at 1:45 p.m., observations revealed that there are combustibles being stored within the working spaces for the electrical panels and the emergency generator transfer switch panel that are located in the electrical/mechanical room in the staff support corridor. This deficient condition was verified by the Maintenance Supervisor.	K 511	K511 Utilities – Gas and Electric Corrective action taken: combustible materials were removed from the electrical panel room. Corrective action taken to address similar issues (if necessary): Maintenance Director, Assistant Maintenance Director, and Administrator will be educated on the need to keep electrical panel room free of all combustible materials. Date of compliance: 3/12/21 Recurrence prevented by: Audits will be conducted monthly to ensure that combustible materials are not stored in the electrical panel room. Corrections monitored by: Corrections will be monitored by Maintenance Director and Administrator of Record	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		4/11/21

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 _____	**02/24/2021**

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 521	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility did not maintain the heating, ventilation, and air conditioning in accordance with the NFPA 101 "The Life Safety Code" 2012 edition, section 9.2, 19.5.2.1., NFPA 90A "Standard for the Installation of Air-Conditioning and Ventilation Systems" 2012 edition, section 5.4.8.1., and NFPA 80 "Standard for Fire doors and Other Opening Protectives" 2010 edition, section 19.4.1.1. This deficient practice could affect 44 of 44 residents. Findings include: On 02/24/2021, at 12:16 p.m., during a review of all available fire and smoke damper maintenance and testing documentation for the last 4 years, and an interview with the Maintenance Supervisor it was revealed that at the time of the inspection the facility had not completed an inspection of the fire and smoke dampers in the last four years. The last inspection was dated 05/24/2016. This deficient condition was confirmed by the facility Maintenance Supervisor.	K 521	K521 HVAC Corrective action taken: Facility will conduct a damper inspection. Corrective action taken to address similar issues (if necessary): Maintenance Director, Assistant Maintenance Director, and Administrator will be educated on the need for the facility to conduct a damper inspection in accordance with life safety code. Date of compliance: 4/11/21 Recurrence prevented by: Maintenance director will ensure that an annual damper inspection is conducted. Corrections monitored by: Corrections will be monitored by Maintenance Director and Administrator of Record	
K 761 SS=E	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.	K 761		3/26/21

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 _____	**02/24/2021**

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 761	Continued From page 11 Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on documentation review, observations, and staff interview, the facility did not complete the annual fire door inspections in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition sections 8.3.3.1, 19.7.6 and the NFPA 80 Standard for Fire Doors and Other Opening Protectives 2010 edition sections 5.2.1. This deficient practice could affect the safety of 20 of 44 residents. Findings include: On 02/24/2021, at 12:46 p.m., during a review of all available fire door test and inspection documentation, and an interview with the Maintenance Supervisor, it was determined that the facility could not provide documentation verifying that the 90 minute fire rated door assembly ceiling access hatch located by the west wing nurses station had been inspected as part of the annual fire door inspection program. This deficient condition was confirmed by a Maintenance Supervisor.	K 761	K761 Maintenance, Inspection, and Testing – Doors Corrective action taken: Ceiling access hatches will be added to routine fire door inspection list for future annual fire door inspection program. Corrective action taken to address similar issues (if necessary): Maintenance Director, Assistant Maintenance Director, and Administrator will be educated on the need for the facility to include ceiling access hatches in the annual fire door inspection program. Date of compliance: 3/26/21 Recurrence prevented by: Maintenance Director will ensure that ceiling access hatches are included in the annual fire door inspection program. Corrections monitored by: Corrections will be monitored by Maintenance Director and Administrator of Record	

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 _____	**02/24/2021**

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 901	Continued From page 12	K 901		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review, observations, and staff interview, the facility did not complete the annual fire door inspections in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition sections 8.3.3.1, 19.7.6 and the NFPA 80 Standard for Fire Doors and Other Opening Protectives 2010 edition sections 5.2.1. This deficient practice could affect the safety of 20 of 44 residents. Findings include: On 02/24/2021, at 12:46 p.m., during a review of all available fire door test and inspection documentation, and an interview with the Maintenance Supervisor, it was determined that the facility could not provide documentation verifying that the 90 minute fire rated door assembly ceiling access hatch located by the west wing nurses station had been inspected as part of the annual fire door inspection program.	K 901	K901: Fundamentals- Building Systems Categories Corrective action taken: Corrective action taken: Ceiling access hatches will be added to routine fire door inspection list for future annual fire door inspection program. Corrective action taken to address similar issues (if necessary): Maintenance Director, Assistant Maintenance Director, and Administrator will be educated on the need for the facility to include ceiling access hatches in the annual fire door inspection program. Date of compliance: 3/26/21 Recurrence prevented by: Maintenance Director will ensure that ceiling access hatches are included in the annual fire door inspection program.	3/26/21

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 _____	**02/24/2021**

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 901	Continued From page 13 This deficient condition was confirmed by a Maintenance Supervisor.	K 901	Corrections monitored by: Corrections will be monitored by Maintenance Director and Administrator of Record	