DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL	
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY	
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ID: DWRM Facility ID: 00844

1. MEDICARE/MEDICAID PROVIDE (L1) 245471 2.STATE VENDOR OR MEDICAID N (L2) 048540300 5. EFFECTIVE DATE CHANGE OF C (L9) 06/01/2019	IO.	3. NAME AND AE (L3) THE WATE (L4) 402 - 13TH A (L5) TWO HARE 7. PROVIDER/SU 01 Hospital	RVIEW SHOI AVENUE BORS, MN	RES LLC	(L6) 55616 <u>02</u> (L7) 13 PTIP 22 CLIA	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation 7. On-Site Visit 8. Full Survey Afte	2. Recertification 4. CHOW 6. Complaint 9. Other
6. DATE OF SURVEY 04/13 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/ 2021 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDI	ING DATE: (L35)
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14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 44 (L37) (L38)	WN 19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REM.	ARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Teresa Ament, Unit Super	visor	0	3/30/2021	(L19)	Joanne Simon, Enforcem	ent Specialist	04/08/2021 (L20
				` /	Joanne Simon, Enforcem	•	
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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



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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL	ID: DWRM
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY	Facility ID: 00844

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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: 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

PRINTED: 03/30/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	l \ '	TE SURVEY MPLETED
						С
		245471	B. WING		02	/25/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
THE WAT	TERVIEW SHORES LI			402 - 13TH AVENUE		
I THE WA	EKVIEW SHOKES LI			TWO HARBORS, MN 55616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00		
F 000	On 2/22/21, throug compliance with CN Preparedness was recertification surve compliance with the Preparedness, Red (LTC) Facilities. INITIAL COMMENT On 2/22/21, throug recertification surve facility. Complaint in conducted. Your factompliance with the Subpart B, Require Facilities. The following compunsubstantials. The following compunsubstantials.	gh 2/25/21, a standard by was conducted at your envestigations were also cility was found not in erequirements of 42 CFR 483, rements for Long Term Care olaints were found to be	FO			
	be used as verificate Upon receipt of an on-site revisit of you validate that substa					
L ABORATOR'		DER/SUPPLIER REPRESENTATIVE'S SIGN	IATLIRE	TITLE		(X6) DATE

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.

Electronically Signed

03/22/2021

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	COMPLETED
		245471	B. WING		C 02/25/2021
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW SHORES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE TWO HARBORS, MN 55616	02/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE COMPLÉTION
	development and i person-centered p limited to: (i) The right to part including the right be included in the request meetings a revisions to the pe (ii) The right to par expected goals an amount, frequency other factors related plan of care. (iii) The right to be changes to the plated (iv) The right to recincluded in the plated (v) The right to see right to sign after sof care. §483.10(c)(3) The	right to participate in the mplementation of his or her lan of care, including but not icipate in the planning process, to identify individuals or roles to planning process, the right to and the right to request rson-centered plan of care. ticipate in establishing the doutcomes of care, the type, and duration of care, and any to the effectiveness of the informed, in advance, of n of care. Service the services and/or items of care. The type is the care plan, including the ignificant changes to the plan facility shall inform the resident	F 553		3/29/21
	and shall support to planning process or (i) Facilitate the incresident represent (ii) Include an assestrengths and need (iii) Incorporate the cultural preference This REQUIREME	clusion of the resident and/or ative. essment of the resident's			
	facility failed to pro	w and document review, the vide the opportunity to are planning process and be		F 553 Right to Participate in Plann Care Immediate Corrective Action:	ing

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION NG		COMI	E SURVEY PLETED
		245471	B. WING			02/2	25/2021
	PROVIDER OR SUPPLIER	_c		STREET ADDRESS, CITY 402 - 13TH AVENUE TWO HARBORS, M		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 553	and/or interventions 1 of 1 resident (R27 conferences. Findings include: R27's Transfer/Disc indicated R27 was 11/11/20, with diagr infarction (stroke), a hypothyroidism, and R27's significant ch (MDS) dated 1/13/2 cognitive impairment R27 to have family R27's care. On 2/22/21, at 5:36 conducted with fam the interview, FM-A concerns regarding stated R27's last ca was admitted. FM- a called or received any upcoming care On 2/25/21, at 10:1 conducted with the (SSD)-A. SSD-A si completed after adi significant change i R27's last care con	charge Report printed 2/25/21, admitted to the facility on noses that included cerebral atrial fibrillation,	F 5	Resident #27 s scheduled to en addressed and with resident an Corrective Action The social serving educated on the conferences aft and with any chall residents will that they are up care conference Date of Complia Recurrence will Audits of 5 residuals will be and then month that they receive conference. The with the facility on the need to in discontinue the Corrections will	s care conference where that any issues to review current cand family. In as it applies to other ices director will be eneed to complete of the red admission, quarter admission, quarter admission, quarter admission, quarter admission, quarter ange in condition. If be reviewed to ensor to date on their request. If be prevented by: If dents care conference conducted weekly ally x 2 months to ensor admission appropriate the results will be shat QAPI committee for increase, decrease of their appropriate of t	s were ire plan hers: care erly, sure uired ence x 4 sure care ired input	
	condition and an M SSD-A verified R27	had a significant change in DS was completed on 1/13/21. did not have a care					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		245471	B. WING_		C 02/25/2021
	PROVIDER OR SUPPLIER	.c		STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE TWO HARBORS, MN 55616	, , , , , , , , , , , , , , , , , , , ,
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	R27's care conference so R27 should have ha R27 had a change in On 2/25/21, 1:17 p. conducted with the The DON stated ca after admission, quachange in a resident The DON stated So conferences and intresident representative scheduled. The facility policy or requested and not resident set of daily services to maintain personal and oral had residents (R1 with activities of daily services, the facility fall of 4 residents (R1 with activities of daily services services and residents (R1 with activities of daily services services and residents (R1 with activities of daily services services services and residents (R1 with activities of daily services services services services services services services and residents (R1 with activities of daily services	nce was not on February's hedule. The SSD-A stated ad a care conference when n condition. m. an interview was director of nursing (DON). re conferences were held arterly, and when a significant at's condition had occurred. SD-A scheduled the care formed residents and/or tives when care conferences n Care Conferences was received. for Dependent Residents 2) ident who is unable to carry y living receives the necessary n good nutrition, grooming, and ygiene; IT is not met as evidenced ion, interview, and document ailed to remove facial hair for 5) reviewed for assistance	F 55		thers: Care ained d on the I per
		R15 was severely cognitively		facial hair removal preferences an	
				The state of the s	1

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F 677	impaired. R15's care plan data required extensive personal care. On 2/22/21, at 6:15 have facial hair alouthat were approxims small area to the right 4-5 hairs that were On 2/23/21, at 1:20 (FM)-A was interview beautician for many mortified" if she reason on 2/24/21, at 7:29 eating breakfast. Runtrimmed. On 2/25/21, at 11:0 (NA)-G was interview facial hair, and was trimmed. NA-G states shower days. The facility policy Massistance Per Cardirected "Based on representative desiplan, ADL assistance residents deemed in would be: Shaving	ted 10/4/19, indicated R15 assistance of one for all p.m. R15 was observed to ng the entire base of the chin ately 1/8th of an inch long. A ght of the chin had a cluster of approximately 1/4 inch long. p.m. R15's family member ewed. FM-A stated R15 was a years, and "would be alized she had facial hair. a.m. was observed with 15's facial hair remained 5 a.m. nursing assistant ewed. NA-G stated R15 had a not sure when they were last ted facial hair was trimmed on donarch Healthcare ADL the Plan revised 5/2018, resident/resident res, assessment and care ce will be provided to any necessary. Some examples (male and female) as needed."	F 67	plan/NAR care sheets will be update 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 m to ensure that they had facial hair removed per care plan/preference. results will be shared with the facilic committee for input on the need to increase, decrease or discontinue audits. Corrections will be monitored by: DON/Nurse Manager/Designee	cted onths The ty QAPI	
F 679 SS=D	Activities Meet Intel CFR(s): 483.24(c)(§483.24(c) Activitie		F 679			3/29/21

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 679	§483.24(c)(1) The the comprehensive and the preference program to support activities, both facilindividual activities designed to meet the physical, mental, a each resident, encand interaction in the This REQUIREME by: Based on observative review, the facility factivities of were post (R27) reviewed for Findings include: R27's Transfer/Disindicated R27 diagrinfarction (stroke) and R27's significant of (MDS) dated 1/13/2 religious activities of the MDS further independent on staff dressing, grooming personal hygiene. R27's Therapeutic 11/13/20, indicated very religious, enjomusic, TV land and continual prompts/	facility must provide, based on assessment and care plan as of each resident, an ongoing tresidents in their choice of lity-sponsored group and and independent activities, he interests of and support the nd psychosocial well-being of ouraging both independence ne community. NT is not met as evidenced tion, interview, and document failed to ensure meaningful rovided to 1 of 1 residents activities. Charge Report printed 2/25/21, noses included cerebral and palliative care. In ange Minimum Data Set 21, indicted R27's family and were very important to R27. Indicated R27 was totally for bed mobility, transfers, g, eating, toileting, and Recreation Evaluation dated R1 had clear speech, was yed Polka and old county of ME TV, required frequent or cueing to engage in group am plan was to attend small	F 67	F 679 Activities Meet Interest Immediate Corrective Action: Resident #27 and family was in to determine activity preference integrate with resident □s care proceed Corrective Action as it applies to The Activity Evaluation Policy were viewed and remained current Activity Director and activity stareducated on need to interview resident/family regarding activity preferences and to integrate the resident care plan and to provious that are meaningful to the resident care plan and to provious that are meaningful to the resident care plan. Date of Compliance: 3/29/21 Recurrence will be integrated in resident care plan. Date of Compliance: 3/29/21 Recurrence will be prevented be Audits of 5 residents will be conweekly x 4 and then monthly x 2 to ensure that care plan has be updated on activity preferences being provided meaningful actives results will be shared with the facommittee for input on the need	s to blan. b others: as c others: as ff will be gem into the le activities ent. erviewed nd these atto the gem into the le activities ent. erviewed and these atto the gem into the le activities en and are gement are activities. The actility QAPI	

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	PROVIDER OR SUPPLIER	_C		40	TREET ADDRESS, CITY, STATE, ZIP CODE 22 - 13TH AVENUE WO HARBORS, MN 55616	<u>, </u>	
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F 679	wishes were to be in programs of interest R27's Care Area Assonselve exhibited short and and staff need to an needs. A nursing assistant lacked indication of church services on On 2/22/21, at 5:23 stated she was unsoffered to R27. FW Catholic and was werequested for staff services on Wednewould like to see R often and have more was once a week to During observations was in was in bed with drawn. No music of During observations was in bed, the ligh was drawn. At 8:57 entered R27's room to drink. R27 decliner back wearing a R27 was in bed lyin or music was on. A and the church services are services on the light was drawn. At 8:57 entered R27's room to drink. R27 decliner back wearing a R27 was in bed lyin or music was on. A and the church services are services of the light was drawn. At 8:57 entered R27's room to drink. R27 decliner back wearing a R27 was in bed lyin or music was on. A and the church services are services of the light was drawn. At 8:57 entered R27's room to drink. R27 decliner back wearing a R27 was in bed lyin or music was on. A and the church services on which was drawn as a light was drawn. At 8:57 entered R27's room to drink. R27 decliner back wearing a R27 was in bed lyin or music was on. A and the church services on which was drawn as a light was drawn.	red 1/7/21, indicated R27 nvited and assisted to group at such as church services. Resessment (CAA) for cognition of 1/26/21, identified R21 long-term memory problems nticipate R21's wants and care guide dated 2/22/21, R27's preference to attend Wednesdays. p.m. family member (FM)-A ure what activities were being l-A stated R27 was a devoted ery religious. FM-A stated she to bring R27 to church sdays. FM-A stated she 27 get out of her room a more re human interactions even if it o go to church. s on 2/23/21, at 9:06 a.m. R27 with the lights off and curtain	F 6	79	increase, decrease or discontinue audits. Corrections will be monitored by: Administrator/Social Services/Desi		

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NAME OF PROVIDER OR SUPPLIER THE WATERVIEW SHORES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE TWO HARBORS, MN 55616	
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F 679	Continued From pa	age 7	F 67	9	
		ns on 2/25/21, at 8:49 a.m. R27 g a hospital gown and no was on.			
	visited R27, R27 w stated it would mea be able to get dres services on Wedne	36 a.m. FM-B stated when she was usually in bed. FM-B an a lot to R27 if R27 were to sed and brought to church esdays. FM-B stated R27 was voted catholic, and always			
	not ask R27 if she church services an seen R27 attend a was admitted. NA	B p.m. NA-H confirmed she did wanted to attend Wednesday of further stated she had not ny church service since R27-H stated R27 preferred to stay ffered to get up, R27 refused.			
	not get out of bed the attend Wednesday R27 would refuse to offered and preferred.	5 p.m. NA-C confirmed R27 did for lunch and was not offered to church services. NA-C stated to get up in her chair when red to stay in bed. NA-C stated do out, and would complain of			
	stated activity assess admission. AD-Assesser provided to reattend regular group one-on-one activiti music, talking, and one-on-one visits with tried to see R27 or stated R27 was Castand R27	B a.m. activity director (AD)-A essments were completed on stated one-on-one activities esidents that were unable to up activities. AD-A stated R27's es included reading books, I holding hands. AD-A stated were not scheduled and she nee weekly for activities. AD-A atholic and tried to have monthly to give R27			

1, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED	
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F 679	communion. AD-A attend Wednesday unaware if staff we to attend. AD-A st preferred to stay in was aware religious to R27, and confirm opportunity to attend. R27's Follow Up Qi to 2/25/21, indicted -On 12/20/20, during Study/Prayer activiti-On 1/6/21, during Study/Prayer activiti-On 1/27/21, during Study/Prayer activiti-On 2/3/21, during Study/Prayer activiti-On 2/10/21, during Study/Prayer activiti-On 2/10/21, during Study/Prayer activiti-On 2/19/21, during Study/Prayer activiti-On 2/19/21, during Study/Prayer activiti-On 2/24/21, during Study/Prayer activiti-On 2/24/21, during Study/Prayer activiti-On 2/24/21, during Study/Prayer activiti-On 2/24/21, at 1:21 documentation of "was sleeping or ha activity charting sysanswers to be chosactivity participation "Family/Friend/Visitiverified, according Report dated 12/29	stated she had not seen R27 church services and was re asking R27 if she would like ated R27 was on hospice and her bed. AD-A stated she is services were very important ned R27 should be given an id. Luestion Report dated 12/27/20 the following: The Religious Service/Bible by, R27 passively participated. Religious Service/Bible by, R27 was not available. The Religious Service/Bible by, R27 was not available.	F 6	79			

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	Service/Bible Study "Resident not availa" On 2/25/21, at 1:17 (DON) stated if a reservices, or treatmer report the refusal to staff were expected document the refusinterventions tried, in DON stated if a resto attend church shather resident an opport of the comprehed evelop an activity part of the comprehed evelop an activity and interests of the directed the resider spirituality, life roles activity pursuit patter included in the evaluation is updated quarterly. Bowel/Bladder Inco CFR(s): 483.25(e)(1) The firesident who is con admission receives	p.m. the director of nursing esident refused cares, ents, staff were expected to the nurse. The DON stated to re-approach a resident and eal, and along with in the medical record. The ident's meaningful activity was e would expect staff to offer ortunity to attend church. Activity Evaluation undated, evaluation is conducted as nensive assessment to help plan that reflects the choices resident. The policy further nt's lifelong interests, s, goals, strength, needs and erns and preferences are uation. The completed activity ed as necessary but at least entinence, Catheter, UTI 1)-(3) The construction of bladder and bowel on services and assistance to				3/29/21	
	resident who is con admission receives maintain continence condition is or beco not possible to main	tinent of bladder and bowel on services and assistance to e unless his or her clinical mes such that continence is ntain.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 02/25/2021	
		245471				
NAME OF	PROVIDER OR SUPPLIEF	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP	•	23/2021
				402 - 13TH AVENUE		
THE WA	TERVIEW SHORES	LLC		TWO HARBORS, MN 55616		
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F 690	comprehensive as ensure that- (i) A resident who indwelling catheter resident's clinical catheterization wa (ii) A resident who indwelling cathete is assessed for reas possible unless demonstrates that and (iii) A resident who receives appropria prevent urinary tracontinence to the §483.25(e)(3) For incontinence, bas comprehensive as ensure that a resireceives appropria restore as much receives appropria restore as much residence as much residence as much residence as much reviews, the facility comprehensive blad been completer reviewed for bower findings include: R14's Face Sheet diagnoses of beni (prostate gland er urinary tract symptimes)	enters the facility without an er is not catheterized unless the condition demonstrates that as necessary; enters the facility with an er or subsequently receives one moval of the catheter as soon is the resident's clinical condition to catheterization is necessary; or is incontinent of bladder at treatment and services to act infections and to restore	F6	F 690 Bowel/Bladder Incommediate Corrective Action Resident #14 had a compand bladder assessment of care plan/NAR care sheet reflect toileting schedule. Corrective Action as it app The Behavior Programs at Plans for Urinary Incontine reviewed and remained out DON and NM were educated complete a comprehensive bladder assessment for ar	on: rehensive bowel completed and was updated to lies to others: nd Toileting ence Policy was urrent. ted on need to e bowel and	

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F 690	affecting left side, vascular demential R14's annual Min 9/22/20, indicated was extensively dependent of needs, did not have always incontinent of as being cognitive level of toileting a MDS documented R14's Urinary Incompared and State of the second of	urinary tract infections, and a with behavioral disturbance. imum Data Set (MDS) dated I R14 was cognitively intact, and ependant on staff for toileting we a toileting plan, and was it of bowel and bladder. IDS dated 12/15/20, indicated ling urinary catheter, and was bowel. R14 was still assessed by intact and needing the same sistance as R14's prior annual d. Interpretation of the same state of the same and the story of the same state of the same and the story of the same start of the same and the story of the same and the story of the same story of the same story of the same and the story of the same story of the same story of the same and the story of the same and the story of the same story of the same and the story of the same and the same story of the same and the same an	F 6	change in condition and to plan/NAR care sheets with All residents will be review that they have had a time bladder assessment and care sheets with results. Date of Compliance: 3/25 Recurrence will be prever Audits of 5 residents will be weekly x 4 and then mont to ensure that a comprehe and bladder assessment completed annually and we significant change and cancare sheets have been up results will be shared with committee for input on the increase, decrease or disaudits. Corrections will be monited DON/NM/Designee	h results. ved to ensure ly bowel and care plan/NAR 2/21 nted by: be conducted thly x 2 months ensive bowel has been with any re plan/NAR bdated. The in the facility QAPI eneed to continue the		

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F 690	R14 also stated the R14 stated that he infections as well. R14's MHM Bladde dated 9/22/20, docuincontinent of bladd medications potenti incontinence. The acomprehensive dethad the potential for incontinence, did not incontinence, lacke inspection of urethrefetermination of an was there any form assessment. R14's care plan last that the section on updated on 2/14/20 the following: "The bladder incontinence diagnosis of [benign The resident will be the review date. Interventions/Tasks - Clean peri-area who Continent unless so night every 2 hours Assist of 1 for urina - Ensure the resident the bathroom - Establish voiding provide medication R14's incontinence	re are times "it just happens." has issues with bladder re Evaluation (assessment) umented only that R14 was ler, his diagnoses, and ially effecting R14's assessment lacked a ermination on whether R14 r reversing/reducing urinary of identify the type of urinary d documentation that a visual al area was performed, lacked individual treatment plan, nor of clinical summary to this t reviewed 2/22/21, indicated R14's bladder needs was last 19. The care plan indicated resident has FUNCTIONAL re [related to] immobility and a n prostatic hyperplasia]. Goal: continent at all times though resident incontinence episode seleeping, check and change at will asked to be toileted. It, assist of 2 for commode. In thas unobstructed path to	F 69				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	(X3) DATE SURVEY COMPLETED C		
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F 690	2/22/21 Day Shift: 6 AM "X' (INC) of bladder, 1: Relief Shift: 2 PM shadder, 4 PM blank Night Shift: 10:30 F continent, 2:30 AM continent 2/23/21 Day Shift: 6-8 AM bladder, 10 AM -12 bowel / bladder Relief Shift: 2 - 4 P and bladder, 4 - 6 F "dry", 8 - 10 PM blank Night Shift - 10:30 continent, 2:30 AM INC of 2/24/21 Day Shift: 6-8 AM continent, 10 AM -continent Relief Shift: 2 - 4 P supper", 6 - 8 PM F supper Shift: 2 - 4 P supper Shift: 3 - 4 P supper Shift: 4 - 10 PM Shift: 5 - 10 PM Shift: 6 - 8 PM F supper Shif	", 8 AM "X", 10 AM incontinent 2 PM blank small INC of both bowel and k, 6 PM blank, 8 PM blank PM INC of bladder, 12:30 AM INC bladder, 4:30 AM INC bladder, 4:30 AM INC of PM "dry", 12 - 2 PM INC of M moderate INC of both bowel PM INC of bladder, 6 - 8 PM	F 690			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245471	B. WING			ı	C / 25/2021
	PROVIDER OR SUPPLIER			402 - 13TI	DDRESS, CITY, STATE, ZIP CODE H AVENUE .RBORS, MN 55616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 690	On 2/24/21, at 11:: (FM)-A was intervinospitalized for unlast year. FM-A stagetting enough flu liquids due to aspire R14 complained at thickened liquids. On 2/24/21, at 11:: and stated R14 was two times a shift, it stated R14 did not only know if he ne bowel movement woffer. On 2/25/21, at 9:5 (CM)-A was interviated being completed frindicating R14 was times a shift, and limit was "Continent un would review R14" The facility policy I Toileting Plans for 10/19, directed the provide guidelines of behavioral interfor a resident with policy had a proceincluded monitorin type of incontinent comprehend "education of the state of the provide guidelines of behavioral interfor a resident with policy had a proceincluded monitorin type of incontinent comprehend "education of the state of the state of the provide guidelines of behavioral interfor a resident with policy had a proceincluded monitorin type of incontinent comprehend "education of the state of the st	I light, and didn't know why. 53 a.m. R14's family member ewed and stated R14 has been inary tract infections over the ated she did not think R14 was ids, because he was on thicken ration concerns. FM-A stated bout the taste and texture of 59 a.m. NA-B was interviewed as incontinent of bladder one to out usually only of urine. NA-B aplace his call light on, and staff edded a urinal place or have a when staff entered the room to 7 a.m. a nursing care manager iewed and stated in regards to displace to bladder assessments not or R14, nursing assistants incontinent of urine one to two R14's care plan indicating R14 less sleeping," stated she	F 6	90			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245471	B. WING		C 02/25/2021	
	PROVIDER OR SUPPLIER	.c		STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE TWO HARBORS, MN 55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION	
F 690	and bowel urge. The facility would be abled (cognitive and physinvolved in a toileting "prompted voiding."	e policy identified how the e to assess a resident's ability ical) / willingness to be g plans and training, including	F 690		2/20/24	
	CFR(s): 483.45(f)(1 §483.45(f) Medicati The facility must en §483.45(f)(1) Medic percent or greater;	on Errors.	F 759		3/29/21	
	Based on observat review, the facility fa were not crush and administered togeth and evaluation, to p	ion, interview, and document ailed to ensure medications mixed together (cocktail) or ner without physician orders brevent adverse interactions (R31, R36, R28) reviewed for tration.		F 759 Free of Medication Error >59 Immediate Corrective Action: Nurse involved was immediately ed on that cocktailing of meds is not appropriate unless there is a specif order. Corrective Action as it applies to oth The Administering Medications thro Enteral Tube Policy was reviewed a	ucated ic MD ners: ugh an	
	R31's Transfer/Disc indicated R31's diag without behavioral of (a disease that cause muscles, such as methoracic spinal pain	charge Report dated 2/24/21, gnoses included dementia disturbance, myasthenia gravis ses weakness in voluntary nuscles for swallowing), and ary Report for active orders as		remained current. All nurses/TMAs were educated that cocktailing (mixing) of medications appropriate for residents who have feeding unless there is an MD order educated that medications can to crushed and mixed together unless is an MD order. All residents who receive medications	at is not a tube r. Also, e there	
	of 2/24/21, included -Tylenol 325 milligra mouth 4 times a da - Pyridostigmine Bro	l orders for: ams (mg); give 2 tablets by		feeding tube or require crushed medications will have MD notified to determine whether crushing and/or of medications is appropriate for the resident.	o mixing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY PLETED
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		245471	B. WING			02/2	25/2021
	PROVIDER OR SUPPLIER TERVIEW SHORES LI	LC		40	TREET ADDRESS, CITY, STATE, ZIP CODE 02 - 13TH AVENUE WO HARBORS, MN 55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 759	60 mg by mouth 3 to libuprofen Tablet 4 for left foot pain for Gabapentin 300 m 600 mg at bedtime spine regular diet, mecho (thin) consistency (regular texture at b R31's Order Summorush or cocktail m R31's Medication A and Treatment Adn 2/21, lacked direction medications. On 2/22/21, at 5:57 (LPN)-B was obsered included Tylenol, Programmedications for adrincluded Tylenol, Programmedications for adrincluded Tylenol, Programmedications for crushin said she could not computer. LPN-B of the diet, so it was OK to together. LPN-B of medications togeth sauce, and added to capsule into the apadministered the more persuading, R31 to prepared. R36's Transfer/Disc	times a day 00 mg by mouth 3 times a day 14 days 19 by mouth 2 times a day and related to pain in thoracic anical soft texture, regular liquids), pureed diet, OK for reakfast. lary Report lacked indication to	F7	759	Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of 5 residents will be conduct weekly x 4 and then monthly x 2 meto ensure that any resident who recurred medications or medication through a PEG tube are administer individually unless there is an MD of that it is ok to mix and administer together. The results will be shared the facility QAPI committee for input the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/NM/Designee	onths eeives s ed order	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245471		1 ' '	l ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP CO 402 - 13TH AVENUE TWO HARBORS, MN 55616		72372021	
(X4) ID PREFIX TAG			ID PREFI TAG	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE	
F 759	malnutrition, and difficulties). R36's Order Summ of 2/24/21, includer-donepezil; give 10 related to Alzheimeretoprolol succination; give 25 mg bedtime related to mirtazapine tablet bedtime related to malnutrition. -regular diet, pure consistency liquids medications crushevery shift related to lacked directives to together, and which crushed. R36's MAR for 2/2 medications to purelated to dysphagidirections to cocktatogether and which crushed.	thm), moderate protein-calorie ysphagia (swallowing mary Report for active orders as d orders for: mg by mouth at bedtime er's disease at extended release (ER) 24 y mouth every morning and at congestive heart failure; give 15 mg by mouth at moderate protein-calorie er meat texture, honey are do dysphagia. R31's order or cocktail crushed medications in medications could be consistency every shift ia. R36's MAR lacked ail crushed medications in medications could be	F 7	,			
	preparing R36's me including donepezi mirtazapine. LPN-small plastic bag a LPN-C verified R36 medications on the directives could no order, and verified	7 p.m. LPN-C was observed edications for administration, I, metoprolol succinate ER, and C put the medications into a nd crushed them together. So had orders for crushing MAR. LPN-C stated to be on the MAR without an R36 did not have orders to together. LPN-C put the					

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 402 - 13TH AVENUE TWO HARBORS, MN 55616		123/2021	
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 759	administered the name R28's Transfer/Disindicated R28's dia atherosclerotic heat and narrowing of ymajor depressive of D deficiency, consignation of 2/24/21, include aspirin tablet cheat morning related to calcium carbonate the morning related to related to disosorbide monomorning and at beautiful to the total control of the morning for supple and the morning for supple for the morning and at beautiful to the m	charge Report dated 2/24/21, agnoses included osteoporosis, art disease (ASHD- hardening our arteries), heart failure, disorder, chronic pain, vitamin tipation, and reflux disease (GERD-when uently flows back into the tube uth and stomach). The age-related osteoporosis ostale give 81 mg in the chronic atrial fibrillation at tablet 600 mg; give 600 mg in dot age-related osteoporosis osule give 1000 units in the age-related to ASHD g; give 40 mg in the morning demia tablet; give one table in the ement of mg; give 1 tablet every ditime for chronic back pain ag in the morning related to Sion elayed release 40 mg; give one tablet in the ostion of the soule of the soule of the disorder one tablet in the option.	F 7	59			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	. ,	(X3) DATE SURVEY COMPLETED	
		245471	B. WING		_ 02	C / 25/2021	
	PROVIDER OR SUPPLIER	_C		STREET ADDRESS, CITY, ST 402 - 13TH AVENUE TWO HARBORS, MN 5	ATE, ZIP CODE		
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F 759	-Medications have through PEG tube (gastrostomy tube pfor enteral feeding, administration) with between. DO NOT TOGETHER, order R28's MAR for 2/21 one at a time through water flushes in between the ADMINISTER MED On 2/24/21, at 7:38 was observed prepadministration. RN into two medication take a plastic bag to When asked if medication to the two medication takes and gave to she found the order time and proceeded individually and put cups. RN-A brough R28's room, and affor residual and flusted the medications from tube one right after between each medication, but her time.	percutaneous endoscopic lace directly into the stomach hydration and medication small water flushes in ADMINISTER MEDICATIONS date 4/6/20. I, directed to give medications the PEG tube with small tween. DO NOT DICATIONS TOGETHER. a.m. registered nurse (RN)-A aring R28's medications for A dispensed the medications cups together, and started to put them into for crushing. Lications were to be crushed uped and said she should a time, but said she usually hem together. RN-A stated to to rush each medication at a distoin the crushed medication them in separate medication them in separate medication them in separate medication to the checking R28's PEG tube shing the tube with a small ut approximately 5 to 10 teach medication cup and the cup into R28's PEG another without flushing ication. RN-A stated R28 did	F 7	59			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			C (X3) DATE SURVEY	
		245471	B. WING _			/25/2021	
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE TWO HARBORS, MN 55616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 759	medications should administered individirected to give easeparated by water medication orders from the hospital, if on the MAR. The Enursing judgement standing orders. To order from the phy The DON also state medications and in separated. On 2/25/21, at 12: pharmacist (CP)-A be co-mingled whe don't know what kit have. CP-A stated order to crush and crushing and cock: CP-A stated they sextended-release reget the proper effect stated they have respectively be crushed, and veradministered separated between each medications, and redications, and redication observed CP-A stated he working. The facility policy C4/18, directed the redications.	ewed and stated R28's d be crushed individually and dually, and verified R28's MAR ch medication individually r. The DON stated they follow when residents are admitted f it says do not crush, and put it DON stated otherwise it was as they have it on their ne DON stated they get an sician to crush medications. ed the pharmacist reviewed adicated if they need to be a dicated if they need to be an an have the pharmacist review for tailing crushed medications. They would not be crushing medication, as they would not ct from the medication. CP-A eviewed R28's medications to be a dication. CP-A stated he had a residents for crushing eviewed R31 and R36's ed to be crushed at this time. Uld review their medications for Crushing Medications revised medical director, DON and CP		59			
	would identify appr	opriate indications and shing medications, and					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	COV	E SURVEY MPLETED
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	PROVIDER OR SUPPLIER	_C		STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE TWO HARBORS, MN 55616	1 021	20/2021
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F 759	directed nursing or physician to crush a manufacturer advis crushed, such as lo medication. The portion of the provide justification modification will not and the nursing state pertinent adverse e indicate why it is near the policy further discrete derivation and addressed that separately may not through an Enteral nursing to administrate and flush between a medications are not Medications. Label/Store Drugs and Enteral further directed to find medications. Label/Store Drugs and Enteral further directed to find medications. Label/Store Drugs and biological labeled in accordant professional princip appropriate access instructions, and the applicable.	CP to notify the ordering a medication when the ed a medication should not be ong-acting or enteric coated olicy directed the physician or alternative medication and/or ment why crushing adversely affect the resident, why the dosage form accompromise the resident for ffects. The MAR must accessary to crush medications, irected medications should be and administered with food, a sometimes giving them be appropriate for a resident. Indicate the medications and ensure to the "Do Not Crush the pharmacy. The policy lush with 15 ml water between and Biologicals h)(1)(2) To of Drugs and Biologicals als used in the facility must be not with currently accepted oles, and include the	F 76			3/29/21
	3.00.10(11) Otorage	S. Drago and Diologicals				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		245471	B. WING			25/2021
	PROVIDER OR SUPPLIER	LC	STREET ADDRESS, CITY, STATE, ZIP COE 402 - 13TH AVENUE TWO HARBORS, MN 55616		•	
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F 761	Federal laws, the fabiologicals in locke temperature control personnel to have a §483.45(h)(2) The locked, permanentl storage of controlle the Comprehensive Control Act of 1976 abuse, except whe package drug distriquantity stored is more readily detected. This REQUIREMED by: Based on observative review, the facility for medications for reviewed for medic. Findings include: R28's Transfer/Distrindicated R28's dia atherosclerotic heat and narrowing of your major depressive of D deficiency, const gastro-esophageal stomach acid frequencements.	accordance with State and acility must store all drugs and d compartments under proper Is, and permit only authorized access to the keys. facility must provide separately y affixed compartments for d drugs listed in Schedule II of a Drug Abuse Prevention and and other drugs subject to a the facility uses single unit bution systems in which the alinimal and a missing dose can but it is not met as evidenced ation, interview, and document ailed to ensure proper labeling 1 of 6 residents (R28) ation administration. Charge Report dated 2/24/21, gnoses included osteoporosis, and the discovery of th	F 76	F 761 Label/Store Drugs and Immediate Corrective Action: Resident #28 s medication of updated to reflect the current dosage/instructions. Corrective Action as it applies The Labeling of Medications reviewed and remained curre All nurses/TMAs were educaneed to ensure that their medication(s). All residents medication carreviewed to ensure that medication to ensure that medication, a sticker will be place to notify nurse/TMA of a medication and the current orders.	card was s to others: Policy was ent. ted on the dication cards nistering the rds will be ication cards hey don the d on the card ication	
	of 2/24/21, included -calcium carbonate	ary Report for active orders as d orders for: tablet 600 mg; give 600 mg in to age-related osteoporosis,		change and to check chart at will be updated. Date of Compliance: 3/29/21 Recurrence will be prevented		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` ´сом	E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP		20/2021
THE WA	THE WATERVIEW SHORES LLC			402 - 13TH AVENUE		
THE WATERVIEW SHORES LEG			TWO HARBORS, MN 55616			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 761	order date 4/6/20. -Norco tablet 5-325	i mg; give 1 tablet every	F 76	Audits of 5 residents will be weekly x 4 and then month	hly x 2 months	
	order date 4/6/20Medications have	Itime for chronic back pain, to be given one at a time (percutaneous endoscopic		to ensure that the medical the current orders. The re- shared with the facility QA for input on the need to in-	sults will be PI committee	
	gastrostomy tube p for enteral feeding, administration) with	lace directly into the stomach hydration and medication small water flushes in ADMINISTER MEDICATIONS		decrease or discontinue the Corrections will be monito DON/NM/Designee		
	TOGETHER, order					
	was observed prep administration. RN	aring R28's medications for -A prepared medications to RN-A dispensed one 500				
	milligram (mg) table a medication cup.	et of Oyster Shell Calcium into RN-A read the label and e Medication Administration				
	Record (MAR) and was to receive one	stated R28's MAR stated R28 600 mg tablet of calcium, but the 500 mg tablets. RN-A said				
	she would call the p	physician to notify them that ed the wrong medication				
	the label did not ma	ked what she would do when atch the orders, she said they medication to alert nursing to				
	would call the phare	on orders. RN-A stated she macy, also. R28's medication 8's bottle of calcium had been				
	sent from the pharr contained 30 tablet	macy on 2/20/21, and had s. 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- 500 mg tablet, sinc	A stated she would give the e it was less than the				
		nd then notify the physician. In co 5-325 mg label read to				

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	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE TWO HARBORS, MN 55616	, , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 761	pain. R28's orders scheduled for twice received new order orders, and the the orders, and the they did not match. The facility policy L 12/19, directed all r would be properly I current state and fe would inform the pl physician orders fo Routine/Emergenc CFR(s): 483.55(b)(\$483.55 Dental Se The facility must as routine and 24-hou \$483.55(b) Nursing The facility- \$483.55(b)(1) Musicutside resource, ii of this part, the follothe needs of each (i) Routine dental sunder the State plat (ii) Emergency den \$483.55(b)(2) Musicussist the resident-(i) In making appoint	let twice daily as needed for indicated R28's Norco was e daily. RN-A stated R28 had is. If p.m. the director of nursing dication labels should match pharmacy should be notified if abeling of Medications dated medications in the facility abeled in accordance with the ederal regulations, and nursing narmacy of any changes in r a medication. If y Dental Srvcs in NFs 1)-(5) Invices asist residents in obtaining r emergency dental care. If provide or obtain from an accordance with §483.70(g) about a services to meet resident: ervices (to the extent covered in); and tal services;	F 76			3/29/21

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		245471	B. WING _			25/2021
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP 402 - 13TH AVENUE TWO HARBORS, MN 55616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 791	residents with lost of dental services. If a 3 days, the facility resident what they did to entand drink adequate services and the expled to the delay; §483.55(b)(4) Must circumstances whe dentures is the facilic charge a resident for dentures determine policy to be the facility for dental expense under the policy to be the facility for dental services. Findings include: R5's Face Sheet produging included dementia, major de Alzheimer's disease.	ations; appromptly, within 3 days, refer or damaged dentures for a referral does not occur within must provide documentation of sure the resident could still eat ally while awaiting dental attenuating circumstances that the have a policy identifying those on the loss or damage of lity's responsibility and may not for the loss or damage of ad in accordance with facility lity's responsibility; and assist residents who are participate to apply for dental services as an incurred ander the State plan. No interview, and document ailed to ensure dental services of 1 residents (R5) reviewed a resident of 1 residents (R5) reviewed a services as an incurred of 1 residents (R5) reviewed a services of 1 residents (R5) reviewed a services of 2/25/21, indicated R5's a didopathic hydrocephalus, appressive disorder, and a Set (MDS) dated 2/16/20,	F 79	F 791 Routine/Emergency Services Immediate Corrective Action Resident #5 had dental apup. Corrective Action as it apponto The Availability of Services was reviewed and remained Social Services Director would need to assist with setting services when needed. All residents were interview to see if they are in need to	pon: pointment set lies to others: pontal Policy d current. as educated on up dental wed/assessed f dental	
	indicated R5 had m	oderately impaired cognition.		services and social service that they have dental appo		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMI	E SURVEY PLETED
		245471	B. WING			C 25/2021
	NAME OF PROVIDER OR SUPPLIER THE WATERVIEW SHORES LLC			STREET ADDRESS, CITY, STATE, ZIP 402 - 13TH AVENUE TWO HARBORS, MN 55616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 791	On 1/3/21, at 11:07 indicated R5 was ethe front permanent saved, R5's spouse. On 1/5/21, at 12:55 indicated R5 had cobroken tooth. A der R5 had no difficulty. On 1/7/21, at 12:17 indicated a dental aworks. R5 had not eating, and denied. R5's Oral/Dental Ethical States and stated his tooth is being set up for 10 On 2/23/21, at 12:02 and stated his tooth January. R5 stated weeks about dentat tooth was not painfrand embarrassing and embarrassing and embarrassing and eworking on get needs to go to Ely. will accept his insult Two Harbors that we FM-B stated it was transport R5 to the not know the status	a.m. a progress note ating popcorn, when one of t teeth broke. The tooth was a was notified. 5 p.m. a progress note omplaints of pain related to the ntal visit was being looked at eating. 7 p.m. a progress note appointment was still in the been having troubles with pain. Waluation dated 2/15/21, at a Summary/Interventions: "Has a denies pain and a dental visit him. No problems with eating." 13 p.m. R5 was interviewed in has been broken since early he "has not heard anything in I appointment." R5 stated the ul, but it had been bothersome because it was a front tooth,	F 79	if requested/needed in a ti Date of Compliance: 3/29 Recurrence will be preven Audits of 5 residents will b weekly x 4 and then month to ensure that if they are ir services that a dental apply being set up in a timely maresults will be shared with committee for input on the increase, decrease or discaudits. Corrections will be monito Administrator Designee/Des	n/21 Ited by: the conducted hily x 2 months in need of dental cointment is anner. The ithe facility QAPI is need to continue the red by:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
		245471	B. WING			C 02/25/2021	
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP COI 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 CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 791	was interviewed an	nge 27 o.m. case manager (CM)-A d stated she did not know R5	F 7	91			
F 880 SS=D	interviewed. SS-As accept all insurance of a few who would finding transportation stated Ely was over companies will transwait for a resident. coordinator (HUC-Eup an appointment however, she had reprivate available to all residental care." Infection Prevention CFR(s): 483.80(a)(§483.80 Infection CThe facility must estinfection prevention designed to provide comfortable environdevelopment and transportation infection program. The facility must estinfection comfortable environdevelopment and transportation program. The facility must estinfection program.	1)(2)(4)(e)(f) Control Stablish and maintain an and control program e a safe, sanitary and ament and to help prevent the ransmission of communicable tions. In prevention and control Stablish an infection prevention on (IPCP) that must include, at	F8	80		3/29/21	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		245471	B. WING _			C / 25/2021
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP C 402 - 13TH AVENUE TWO HARBORS, MN 55616		720,2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			N SHOULD BE	(X5) COMPLETION DATE
F 880	reporting, investiga and communicable staff, volunteers, viproviding services of arrangement based conducted accordinaccepted national significance for the but are not limited to (i) A system of survice possible communication infections before the persons in the facil (ii) When and to whom when the facil (iii) Standard and the to be followed to provide (iv) When and how resident; including (A) The type and do depending upon the involved, and (B) A requirement to least restrictive posticumstances. (v) The circumstant must prohibit employed contact with resident contact will transmit (vi) The hand hygien	stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual dupon the facility assessmenting to §483.70(e) and following standards; en standards, policies, and program, which must include, oc: eillance designed to identify sable diseases or ey can spread to other sity; nom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct ints or their food, if direct	F 88			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245471	B. WING			C 25/2021	
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP 402 - 13TH AVENUE TWO HARBORS, MN 55616	STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE			
F 880	§483.80(a)(4) A sysidentified under the corrective actions to \$483.80(e) Linens. Personnel must hait transport linens so infection. §483.80(f) Annual in The facility will conclibe and update the This REQUIREMED by: Based on observative review, the facility fipersonal protection (put on) before entequarantine for 1 of transmission-based facility failed to ensilinen, and hand hyppersonal cares to part of 4 residents (R3 cares. Findings include: R29's Transfer/Discindicated R29 diagner failure, and as R29's admission M1/26/21, indicated R29 was selected.	stem for recording incidents facility's IPCP and the aken by the facility. Indle, store, process, and as to prevent the spread of review. Iduct an annual review of its neir program, as necessary. In is not met as evidenced tion, interview, and document ailed to ensure proper equipment (PPE) was donned ering a resident's room on 1 resident (R29) reviewed for a precautions. In addition, the ture proper handling of soiled giene was performed during revent cross contamination for an appropriate to the presentation of the precautions. In addition, the ture proper handling of soiled giene was performed during revent cross contamination for an appropriate to personal contact the proper handling of soiled giene was performed during revent cross contamination for the proper handling of soiled giene was performed during revent cross contamination for the proper handling of soiled giene was performed during revent cross contamination for the proper handling of soiled giene was performed during revent cross contamination for the proper handling of soiled giene was performed during revent cross contamination for the proper handling of soiled giene was performed during revent cross contamination for the proper handling of soiled giene was performed during revent cross contamination for the proper handling of soiled giene was performed during revent cross contamination for the proper handling of soiled giene was performed during revent cross contamination for the proper handling of soiled giene was performed during revent cross contamination for the proper handling of soiled giene was performed during revent cross contamination for the proper handling of soiled giene was performed during revent cross contamination for the proper handling of soiled giene was performed during revent cross contamination for the proper handling of the proper hand	F 8	F 880 Infection Control Immediate Corrective Actic Signage on resident #29 updated to reflect current of PPE use. NAR responsible in infection control during sobservation was immediat appropriate process for ha glove changes, and carryir out of room. Corrective Action as it app The Soiled Laundry and Bowas reviewed and remained All facility staff including the educated on need to follow the doors regarding PPE use. CNAs are being educated change gloves and washin between tasks before touch items/areas as well as placed items in a bag before leaving throwing them in the appropriate process and washing the process and washi	s room was guidelines for e for the breach surveyor ely educated on ndwashing, ng soiled items lies to others: edding Policy ed current. erapy were of the signage on ise. Nurses and on the need to lands in going hing other cing soiled ng a room and opriate e quarantine or		

245471 B. WING 02/2/2	5/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	0/2021
402 - 13TH AVENUE	
THE WATERVIEW SHORES LLC TWO HARBORS, MN 55616	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
The state of the appropriate PPE signage is posted on the door. 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 gown whenever anticipating that clothing will be in contact with bodily secretionsDisinfect 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 door. PT-A and OT-A were observed wearing gloves, eye protection and a surviced mask PT-A and OT-A were observed wearing gloves, eye protection.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED C	
		245471	B. WING _		02	//25/2021	
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP 402 - 13TH AVENUE TWO HARBORS, MN 55616			
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F 880	were not wearing g to stand. NA-C ver wheelchair with the PT-A and OT-A we On 2/24/21, at 11:1 R29 's room withou and performed hand On 2/24/21, at 11:2 they were working strengthening after hospital 2/22/21. FR29 up and out of I stated they were in nursing from anoth was only needed w bodily fluids. PT-A followed the signage what PPE to wear, door directed to we in contact with bodi On 2/24/21, at 1:58 pathologist (SLP)-A and gloves were to resident's room on gown was only need a resident's bodily fleducated on prope corporate facility. On, 2/24/21, at 1:58 stated when cleaning was not needed sir resident. H-A stated and a mask were in the proper corporate facility.	owns and were assisting R29 rified he observed R29 in his a walker in front of R29, and re assisting R29 to stand. 9 a.m. PT-A and OT-A exited at wearing a gown or gloves and hygiene. 10 a.m. OT-A and PT-A stated with R29 on endurance and R29's returned from the PT-A stated she was able to get bed today. OT-A and PT-A structed by a director of er corporate facility, a gown then coming in contact with and OT-A both stated they ge on the resident's door in PT-A stated the sign on R29's ear a gown only when coming ily secretions. 8 p.m. speech therapist a stated eye protection, mask be worn before entering a quarantine. SLP-A stated a reded if coming into contact with fluids. SLP-A stated she was a PPE by a DON at another	F 88	0			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED C	
		245471	B. WING				25/2021	
	PROVIDER OR SUPPLIER	_C		402	EET ADDRESS, CITY, STATE, ZIP CODE - 13TH AVENUE O HARBORS, MN 55616	, 02		
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F 880	entering a quarantii mask, gloves, and a observed the signal verified the it was ir on a gown was requested to the sign and R29's door. RN-B was from anther Molow on PPE. RN-B on PPE. On 2/24/21, 2:13 p. (PT)-B stated theral guidelines the facility PPE use. R39's Transfer/Discindicated R39's diagration of the sign and wedge fourth lumbar verter. R39's admission MR39 had moderated dependent on staff hygiene. R39's MD indwelling catheter. On 2/24/21, at 7:39 personal cares, NA and handed it to R3 assisted R39's removed the sign and provided to the sign and provided to R39's bed. NA-H of the sign and sign of leg bag tubing with a stip of leg bag tubing the sign and the sign of leg bag tubing the sign and the sign of leg bag tubing the sign and the sign of leg bag tubing the sign and the sign of leg bag tubing the sign and the sign of leg bag tubing the sign and the sign of leg bag tubing the sign and	ne room eye protection, a a gown were needed. RN-B ge outside R29's door and neorrect. RN-B stated putting uired when coming in close RN-B further stated she would d print the correct signage for stated the language in the sign onarch facility which had been verified the facility was not low m. the director of therapy py staff were to follow the ty had in place for the proper charge Report printed 2/25/21, gnoses included acute kidney compression fracture of the bra. DS dated 2/8/21, indicated y impaired cognition and was for toileting and personal os further indicated he had an	F8	80				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE			402	EET ADDRESS, CITY, STATE, ZIP CODE - 13TH AVENUE O HARBORS, MN 55616	<u>, 02,</u>	20,2021
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F 880	drainage bag, pla drainage bag in a towel. Wearing the R39's bottom, asset the soiled towels. NA-A removed the hand hygiene, put assisted R39 into R39's bed, picked into a charger, pla and handed R39 removed a garbag and put in a new linens from the ot chest and arm, are carried the bundle hallway without be hallway floor, and shower room and then washed hand On 2/24/21, at 8:0 linens should be pleaving a resident infection and drop soiled linens should be catheter care. No be performed before the soiled line of the part of the	ced the catheter drainage basin and covered it with a ne soiled gloves, NA-A washed sisted him to dress, and placed on an extra bed in R39's room. eir soiled gloves, did not perform ton a clean pair of gloves, and a recliner chair. NA-H made I up R39's cell phone, plugged it aced a tray table in front of R39, his hearing aides. NA-H ge bag from the garbage can, loag. NA-H picked up the dirty her bed, held them against his and exited R39's room. NA-H e of soiled linens down the carried the soiled linens to the placed in the hamper. NA-H	F	380			
	(DON) stated staf protection, a surg isolation gown be The DON stated t	32 p.m. the director of nursing if were expected to wear eye ical mask, gloves, and an fore entering a quarantine room. Therapy staff were expected to delition to the rest of the PPF as					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245471	B. WING				C 25/2021
	PROVIDER OR SUPPLIER TERVIEW SHORES L			402 - 1	T ADDRESS, CITY, STATE, ZIP CODE 13TH AVENUE HARBORS, MN 55616	•	
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F 880	therapists often har residents. The DO risk for contaminar spread infection to soiled linen should body to ensure the and soiled linen should be a resident's rodisease. The DOI hand hygiene should be a resident's rodisease. The DOI hand hygiene should be a resident surinary contamination and the facility policy of revised date 1/25/COVID-19 PPE should be respirator is not an	and direct contact with the DN stated this increased the ting clothing and the potential to o others. The DON stated It be handled away from the ere was no cross-contamination mould be bagged before leaving om to prevent the spread of N stated glove changes and all be performed after or catheter care to prevent cross I spread of disease. Coronavirus (COVID-19) 21, directed all recommended mould be worn during care of poservation, which includes use evel respirator (or facemask if a vailable), eye protection, (i.e., in (if facility supplies allow). Handwashing, dated 11/19, thene was to be completed after ent products or cleaning up to has used the toilet, after and before donning gloves,	F	380			



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 <u>only a suggestion</u> 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.

The Waterview Shores Llc March 12, 2021 Page 2

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

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

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

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

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE COM			SURVEY LETED	
		00844	B. WING		02/2	5/2021
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 02/2	0,2021
THE WA	TERVIEW SHORES LI	C	H AVENUE RBORS, MN	55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	Department's staff	n 2/25/21, surveyors of this visited the above provider and tion orders are issued. In				
	The following comp	laints were found to be				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/22/21 **Electronically Signed**

TITLE

STATE FORM 6899 DWRM11 If continuation sheet 1 of 36

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00844	B. WING		l l	C 25/2021	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THE WA	TERVIEW SHORES LI	C	H AVENUE RBORS, MN	55616			
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2 000	UNSUBSTANTIATE H5471018C H5471020C H5471021C Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state sta listed in the "Summ column and replace the correction order the findings which a statute after the sta as evidence by." Fo are the Suggested Time period for Cor You have agreed to receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si obul.htm The State delineated on the a Department of Hea you electronically. is necessary for Sta enter the word "corr text. You must then State licensure proc completion date, the corrected prior to el Minnesota Departm	enent of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for the assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" the "To Comply" portion of the state tement, "This Rule is not met following the surveyors findings the surveyors t	2 000				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED	
			A. BOILDING.		С	
		00844	B. WING			5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW SHORES LI	C	H AVENUE BORS, MN	55616		
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PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREMI CORRECTION FO	N OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF				
2 570	MN Rule 4658.0405 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			3/29/21
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required				
	by: Based on interview facility failed to prov participate in the ca included in decision and/or interventions 1 of 1 resident (R27 conferences. Findings include: R27's Transfer/Disc	and document review, the vide the opportunity to are planning process and be as about care, treatment in the required time frame for 7) reviewed for care charge Report printed 2/25/21, admitted to the facility on		F 553 Right to Participate in Plant Care Immediate Corrective Action: Resident #27 s care conference scheduled to ensure that any issuraddressed and to review current with resident and family. Corrective Action as it applies to on The social services director will be educated on the need to complete conferences after admission, quant and with any change in condition.	was es were care plan others:	

Minnesota Department of Health STATE FORM

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00844	B. WING		C 02/25/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TUE \A/A	TEDVIEW CHOREC I I	402 - 13TH	AVENUE			
INE WA	TERVIEW SHORES LL	TWO HAR	BORS, MN	55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 3	2 570			
2 010	11/11/20, with diagrinfarction (stroke), a hypothyroidism, and R27's significant ch (MDS) dated 1/13/2 cognitive impairmer R27 to have family R27's care. On 2/22/21, at 5:36 conducted with fam the interview, FM-A concerns regarding stated R27's last cawas admitted. FM-a called or received any upcoming care On 2/25/21, at 10:1 conducted with the	noses that included cerebral atrial fibrillation,		All residents will be reviewed to en that they are up to date on their recare conferences. Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of 5 residents□ care conferschedule will be conducted weekly then monthly x 2 months to ensure they received their appropriate car conference. The results will be shwith the facility QAPI committee for the need to increase, decrease discontinue the audits. Corrections will be monitored by: Administrator Designee/Designee	ence x 4 and that e that e ared or input	
	completed after adra significant change in R27's last care condition 27's SSD-A stated R27 is condition and an MI SSD-A verified R27 conference with R2 R27's care conference so R27 should have had R27 had a change in Conducted with the The DON stated cate after admission, quality is last care admission, quality is last care.	mission, quarterly, and with a n condition. SSD-A stated ference was on 11/25/20, at admission care conference. The stated as significant change in DS was completed on 1/13/21. It did not have a care 7's change in condition, and not was not on February's hedule. The SSD-A stated and a care conference when				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
		00844	B. WING		02/2	5/2 021
	PROVIDER OR SUPPLIER	STREET AD 402 - 13TI	DRESS, CITY, S H AVENUE RBORS, MN	STATE, ZIP CODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 570	The DON stated SS conferences and in resident representative scheduled. The facility policy or requested and not a SUGGESTED MET. The social worker crevise procedure wand participation of representative in playorker/designee conterdisciplinary teal ensure compliance.	SD-A scheduled the care formed residents and/or atives when care conferences on Care Conferences was received. THOD OF CORRECTION: or designee could review and atth care conference scheduling residents and/or anning of care. The social build coordinate with m and resident and monitor to	2 570			
2 910	Subp. 5. Incontiner have a continuous management to recunnecessary use of comprehensive reshome must ensure A. a resident without an indwellinunless the resident that catheterization B. a resident where the receives appropriate prevent urinary trace	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home g catheter is not catheterized is clinical condition indicates was necessary; and no is incontinent of bladder e treatment and services to it infections and to restore as er function as possible.	2 910			3/29/21

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SURVEY ETED
5/2021
(X5) COMPLETE DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: (X3) DATE S						
		00844	B. WING		I	C 2 5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	-	
THE WA	TERVIEW SHORES LI	C	H AVENUE	FF040		
	OLIMANA DV. OTA		RBORS, MN		TION	0.50
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 6	2 910			
	needed. He doesn't toileting, unsure if he is on a check ar offering the urinal if On 2/22/21, at 5:30 sitting in bed eating requested. R14 was yellow disposable s On 2/22/21, at 6:15 and stated staff hele R14 stated the nursury and he also will plate the urge to have a kental R14 also stated the legal of the lega	r urinal every 2 hours and as a ask staff to assist with the is aware of his need to void and change schedule with dry." p.m. R14 was observed the evening meal he as noted to be sitting on a light oaker (incontinent) pad. p.m. R14 was interviewed p him with urinal placement. Sing assistants check on him, are on his call light if he feels powel movement or urinate. The are times "it just happens." thas issues with bladder				
	dated 9/22/20, docuincontinent of bladd medications potenti incontinence. The acomprehensive dethad the potential foincontinence, did no incontinence, lacke inspection of urethr determination of an was there any form assessment. R14's care plan last that the section on updated on 2/14/20 the following: "The bladder incontinence."	r Evaluation (assessment) umented only that R14 was ler, his diagnoses, and ally effecting R14's assessment lacked a ermination on whether R14 r reversing/reducing urinary ot identify the type of urinary d documentation that a visual al area was performed, lacked individual treatment plan, nor of clinical summary to this t reviewed 2/22/21, indicated R14's bladder needs was last 19. The care plan indicated resident has FUNCTIONAL the [related to] immobility and a man prostatic hyperplasia]. Goal:				

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	TO CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00844	B. WING		02/2	; :5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW SHORES LI	C	HAVENUE BORS, MN	55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 910	The resident will be the review date. Interventions/Tasks - Clean peri-area w - Continent unless snight every 2 hours Assist of 1 for urina - Ensure the reside the bathroom - Establish voiding provide medication R14's incontinence nursing assistants, 2/22/21 Day Shift: 6 AM "X" (INC) of bladder, 12 Relief Shift: 2 PM shadder, 4 PM bland Night Shift: 10:30 Pcontinent, 2:30 AM continent 2/23/21 Day Shift: 6-8 AM phadder, 10 AM -12 bowel / bladder Relief Shift: 2 - 4 Pland bladder, 4 - 6 Pidry", 8 - 10 PM bland Night Shift - 10:30 Pcontinent, 2:30 AM INC of 2/24/21 Day Shift: 6-8 AM continent, 10 AM -1 continent, 10 AM -1 continent	continent at all times though: ith each incontinence episode sleeping, check and change at . Will asked to be toileted. I, assist of 2 for commode. In thas unobstructed path to coattern in sper MD orders." tracking sheets used by the documented the following: , 8 AM "X", 10 AM incontinent 2 PM blank in the path of both bowel and k, 6 PM blank, 8 PM blank in the path of bladder, 12:30 AM incontinent in the path of bladder, 4:30 AM incontinent in the path of bladder, 6 - 8 PM incontinent in the path of bladder, 6 - 8 PM	2 910			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00844	B. WING		02/2	5/2021	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THE WA	TERVIEW SHORES L	l C	H AVENUE RBORS, MN	55616			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 910	Continued From pa	 ige 8	2 910				
	supper", 6 - 8 PM la 8 - 10 PM blank Night Shift - 10 PM	arge INC of both bowel and - 12 AM INC of urine, 12 - 2 AM continent, 4 - 6 AM INC					
	was interviewed an of bladder one to two sometimes with bounder posted at the staff offer R14 toile may be during a two documentation about the staff of the staf	'a.m. nursing assistant (NA)-A d stated R14 was incontinent vo times during a shift, wel. Referring to the care nurses station, NA-A stated ting every two hours, but it o hour time frame (see ove). NA-A stated R14 did not light, and didn't know why.					
	(FM)-A was intervied hospitalized for uring last year. FM-A state getting enough fluid liquids due to aspiration.	3 a.m. R14's family member ewed and stated R14 has been hary tract infections over the ted she did not think R14 was ds, because he was on thicken ation concerns. FM-A stated yout the taste and texture of					
	and stated R14 was two times a shift, be stated R14 did not only know if he nee	9 a.m. NA-B was interviewed s incontinent of bladder one to ut usually only of urine. NA-B place his call light on, and staff eded a urinal place or have a when staff entered the room to					
	(CM)-A was intervied both the bowel and being completed for indicating R14 was times a shift, and R	a.m. a nursing care manager ewed and stated in regards to bladder assessments not or R14, nursing assistants incontinent of urine one to two R14's care plan indicating R14 ess sleeping," stated she					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI COMPLET (X4) DESCRIPTION (X3) DATE SUI COMPLET (X4) DESCRIPTION (X3) DATE SUI COMPLET (X4) DESCRIPTION (X5) DATE SUI COMPLET					
		00844	B. WING		02/2	5/2 021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
THE WAT	TERVIEW SHORES LI	C:	H AVENUE RBORS, MN	55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	would review R14's The facility policy B Toileting Plans for U 10/19, directed the provide guidelines of behavioral intervi- for a resident with u policy had a procedincluded monitoring type of incontinence comprehend "educa- with instructions", s and bowel urge. Th facility would be ab- (cognitive and phys- involved in a toiletir "prompted voiding." SUGGESTED MET The Director of Nur- develop, review, an procedures to ensu bladder assessmer The Director of Nur- educate all appropri procedures. The Director of Nur- develop monitoring compliance.	ehavior Programs and Urinary Incontinence revised purpose of the policy "is to for the initiation and monitoring entions and/or a toileting plan urinary incontinence." The lure for assessment, which y voiding patterns, determining e, if a resident is able to ation efforts and follow through uch as identification urinary e policy identified how the le to assess a resident's ability ical) / willingness to be ng plans and training, including "THOD OF CORRECTION: sing or designee could d/or revise policies and re comprehensive bowel and	2 910			
2 920		5 Subp. 6 B Rehab - ADLs of daily living. Based on the	2 920			3/29/21
		ident assessment, a nursing				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE : COMPI	
		00844	B. WING		02/2	5/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
THE WAT	TERVIEW SHORES LI	402 - 13Ti	H AVENUE			
THE WA	TERVIEW SHORES LI	TWO HAR	RBORS, MN	55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 10	2 920			
	activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	by: Based on observati review, the facility for 1 of 4 residents (R1) with activities of dail Findings include: R15's Face Sheet p	printed 2/26/21, indicated		F 677 ADL Care Immediate Corrective Action: Resident #15□s facial hair was re Corrective Action as it applies to o The policy for ADL Assistance per Plan Policy was reviewed and rem current. Nurses and CNAs will be educate	thers: Care nained d on the	
	R15's quarterly Min 12/15/20, indicated impaired. R15's care plan dat required extensive personal care. On 2/22/21, at 6:15	cluded unspecified dementia. imum Data Set (MDS) dated R15 was severely cognitively ted 10/4/19, indicated R15 assistance of one for all p.m. R15 was observed to		need to provide facial hair removal care plan/preference. All residents will be reviewed to as facial hair removal preferences an plan/NAR care sheets will be upda 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 nensure that they had facial hair resper care plan/preference. The residents	sk about ad care ated. Icted nonths to moved sults will	
	have facial hair alor that were approxim small area to the rig 4-5 hairs that were On 2/23/21, at 1:20 (FM)-A was intervie beautician for many mortified" if she rea On 2/24/21, at 7:29	ng the entire base of the chin ately 1/8th of an inch long. A ght of the chin had a cluster of approximately 1/4 inch long. p.m. R15's family member wed. FM-A stated R15 was a yyears, and "would be lized she had facial hair. a.m. was observed with 15's facial hair remained		be shared with the facility QAPI co for input on the need to increase, decrease or discontinue the audits Corrections will be monitored by: DON/Nurse Manager/Designee	ommittee	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	E SURVEY IPLETED	
		00844	B. WING			25/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
THE WA	TERVIEW SHORES LI	C.	H AVENUE RBORS, MN	55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 920	untrimmed. On 2/25/21, at 11:0 (NA)-G was intervied facial hair, and was trimmed. NA-G states shower days. The facility policy Massistance Per Cardirected "Based on representative desiplan, ADL assistance residents deemed rewould be: Shaving SUGGESTED MET The Director of Nurdevelop, review, and procedures to ensure provided for dependent to the Director of Nurdeducate all appropring procedures. The Director of Nurdevelop monitoring compliance.	5 a.m. nursing assistant ewed. NA-G stated R15 had not sure when they were last ted facial hair was trimmed on donarch Healthcare ADL re Plan revised 5/2018, resident/resident res, assessment and care ce will be provided to any necessary. Some examples (male and female) as needed." THOD OF CORRECTION: This is good to shaving are grooming, to shaving are	2 920			
21325	, ,	5 Subp. 1 Providing Routine & ealth Ser	21325			3/29/21
	home must provide resource, routine de	e dental services. A nursing e, or obtain from an outside ental services to meet the dent. Routine dental services				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		00844	B. WING		02/2	; 5/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TUE \A/A	TERVIEW SHORES LI	402 - 13Ti	H AVENUE			
INE WA	IERVIEW SHORES LI	TWO HAR	RBORS, MN	55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21325	Continued From pa	ge 12	21325			
	fillings and crowns, oral surgery, bridge orthodontic procedu that are provided fo community at large reimbursement poli	ninations and cleanings, root canals, periodontal care, s and removable dentures, ures, and adjunctive services or similar dental patients in the , as limited by third party cies.				
	by: Based on observati review, the facility for the services. Findings include: R5's Face Sheet prediagnoses included	on, interview, and document ailed to ensure dental services of 1 residents (R5) reviewed inted 2/25/21, indicated R5's idiopathic hydrocephalus, pressive disorder, and		F 791 Routine/Emergency Dental Immediate Corrective Action: Resident #5 had dental appointme up. Corrective Action as it applies to of The Availability of Services, Denta was reviewed and remained curre Social Services Director was educated to assist with setting up dental services when needed. All residents were interviewed/assiste if they are in need of dental services.	ent set thers: Il Policy nt. cated on cal	
	indicated R5 had m On 1/3/21, at 11:07 indicated R5 was e- the front permanen saved, R5's spouse On 1/5/21, at 12:55 indicated R5 had co broken tooth. A der R5 had no difficulty On 1/7/21, at 12:17 indicated a dental a	p.m. a progress note omplaints of pain related to the stal visit was being looked at. eating. p.m. a progress note oppointment was still in the opeen having troubles with		and social services will ensure that have dental appointment set up if requested/needed in a timely man 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 nensure that if they are in need of services that a dental appointmen being set up in a timely manner. Tresults will be shared with the faci committee for input on the need to increase, decrease or discontinue audits. Corrections will be monitored by: Administrator Designee/Designee	at they aner. acted anonths to dental t is the lity QAPI the	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00844	B. WING			C 25/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
THE WA	TERVIEW SHORES LI	C:	H AVENUE			
040.15	CLIMMA DV CTA		BORS, MN		OTION!	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21325	Continued From pa	ge 13	21325			
	5:40 p.m. indicated a new broken tooth is being set up for hone of the control of	valuation dated 2/15/21, at discummary/Interventions: "Has it discummary/Interventions: "Has it, denies pain and a dental visit him. No problems with eating." 3 p.m. R5 was interviewed in has been broken since early the "has not heard anything in appointment." R5 stated the full, but it had been bothersome because it was a front tooth, see it." om. R5's family member ewed and stated, "The nurses ing [R5] to a dentist, [R5] There is a dentist in Ely that rance. There is no dentist in will accept Medicaid insurance." not possible for her to dentist. FM-B stated she did to of the dental appointment or has not heard back from				
	On 2/24/21, 11:25 p	o.m. case manager (CM)-A d stated she did not know R5				
	interviewed. SS-As accept all insurance of a few who would finding transportation stated Ely was over companies will tran wait for a resident. coordinator (HUC-Eup an appointment)	m. social service (SS)-A was stated area dentists refuse to es, the dentist in Ely was one accept R5's. SS-A stated on was also difficult. SS-A ran hour away, and transport sport to Ely, but drivers will not SS-A stated a health unit B) had been working on setting and arranging transportation, esigned the first week of				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		(3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
					C	•	
		00844	B. WING			5/2021	
					<u> </u>	0,2021	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THE WAT	TERVIEW SHORES LI	_C 402 - 13TH					
		TWO HAR	BORS, MN	55616			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE	
		,	.,	DEFICIENCY)			
21325	Continued From pa	go 14	21325				
21020	Continued From pa	ge 14	21323				
	February.						
		vailability of Services, Dental					
		d "Dental services are					
	dental care."	lents routine and emergency					
	dental care.						
	SUGGESTED MET	HOD OF CORRECTION:					
		sing or designee could					
		d/or revise policies and					
		re residents are provede with					
	routine and emerge						
		sing or designee could iate staff on the policies and					
	procedures.	late stall of the policies and					
	•	sing or designee could					
		systems to ensure ongoing					
	compliance.	, , ,					
		R CORRECTION: Twenty-one					
	(21) days.						
21375		Subp. 1 Infection Control;	21375			3/29/21	
	Program						
	Subpart 1 Infection	on control program. A nursing					
		sh and maintain an infection					
		signed to provide a safe and					
	sanitary environme						
	•						
	•	ent is not met as evidenced					
	by:	important		C 000 Infantion Control			
		on, interview, and document ailed to ensure proper		F 880 Infection Control Immediate Corrective Action:			
		equipment (PPE) was donned		Signage on resident #29 □s room v	vae		
	(nut on) hefore ente	ering a resident's room on		updated to reflect current guideline			
		1 resident (R29) reviewed for		PPE use. NAR responsible for the			

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	
711101 127111	OF CONTRACTION	IBENTI IO/MICINIBEN	A. BUILDING:			
		00844	B. WING		C 02/2 5	5/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TI IF 14/4		402 - 13TH	AVENUE			
THE WA	TERVIEW SHORES LI	-C TWO HAR	BORS, MN	55616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 15	21375			
	transmission-based facility failed to ens linen, and hand hyg personal cares to p 1 of 4 residents (R3 cares. Findings include: R29's Transfer/Disc indicated R29 diagrams heart failure, and as R29's admission M	If precautions. In addition, the sure proper handling of soiled giene was performed during revent cross contamination for (39) reviewed for personal charge Report printed 2/25/21, noses included congestive sthma.		in infection control during surveyor observation was immediately educappropriate process for handwash glove changes, and carrying soiled out of room. Corrective Action as it applies to on The Soiled Laundry and Bedding Factorial was reviewed and remained current All facility staff including therapy we educated on need to follow the significant the doors regarding PPE use. Nurchange gloves and wash hands in between tasks before touching others.	cated on ing, ditems thers: Policy nt. ere nage on ses and need to going ner	
	R29's Discharge In indicated R29 was to 2/22/21, and retu 2/22/21. On 2/24/21, at 10:5 (PT)-A and occupations observed entering I protection and a su	R29 was cognitively intact. structions dated 2/22/21, was hospitalized from 2/18/21, irned to the care center on 6 a.m. physical therapist tional therapist (OT)-A were R29's room wearing eye rgical mask, and gloves. PT-A ut on an isolation gown prior to		items/areas as well as placing soil in a bag before leaving a room and throwing them in the appropriate receptacle. All resident rooms who are quarar isolation will be reviewed to ensure the appropriate PPE signage is pothe door. Date of Compliance: 3/29/21 Recurrence will be prevented by: Audits of all residents in isolation of quarantine will be conducted week	atine or e that sted on	
	entering R29's roor quarantine after his hospitalization). On 2/24/21, at 10:5 observed to have a R29's door and indiquarantine/contact directed: -Perform hand hygi before leaving the r-Wear gloves a who	n (R29 was on 14-day re-admission from a 7 a.m. R29's door was stop sign on the outside of cated R29 was on a 14-day droplet precautions and ene before entering and		and then monthly x 2 months to er that the appropriate signage is post the resident door and that staff entare wearing appropriate PPE. The will be shared with the facility QAP committee for input on the need to increase, decrease or discontinue audits. Audits of 5 residents will be conducted weekly x 4 and then monthly x 2 mensure that staff are changing glownshing hands in going between the before touching other items/areas as placing soiled items in a bag be	nsure sted on tering results of the cted nonths to ves and asks as well	

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AND DI AN OF CORRECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00844	B. WING		02/2	; 5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
THE WA	TERVIEW SHORES LI	C	H AVENUE			
		TWO HAI	RBORS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 16	21375			
	proximityWear mask when every gown whene will be in contact with proper cuff [BP], thermone on 2/24/21, at 10:5 (RN)-C stated if physical and protection, mass staff were to go into minutes and had not the environment, a	entering room. ever anticipating that clothing th bodily secretions. In after use. (blood pressure eters etc). 9 a.m. registered nurse exical contact with R29 was was to be worn along with R29's room for less than 15 to physical contact with R29 or gown was not needed.		leaving a room and throwing then appropriate receptacle. The resu shared with the facility QAPI com input on the need to increase, deciscontinue the audits. Corrections will be monitored by: DON/NM/Designee	Its will be mittee for	
	(NA)-C knocked an and OT-A were obs protection, and a su were not wearing goto stand. NA-C ver wheelchair with the	5 a.m. nursing assistant d opened R29's door. PT-A erved wearing gloves, eye urgical mask. PT-A and OT-A owns and were assisting R29 ified he observed R29 in his walker in front of R29, and re assisting R29 to stand.				
		9 a.m. PT-A and OT-A exited t wearing a gown or gloves d hygiene.				
	they were working was rengthening after hospital 2/22/21. PR29 up and out of bestated they were insurang from another was only needed who bodily fluids. PT-A followed the signage what PPE to wear.	0 a.m. OT-A and PT-A stated with R29 on endurance and R29's returned from the T-A stated she was able to get bed today. OT-A and PT-A structed by a director of er corporate facility, a gown hen coming in contact with and OT-A both stated they e on the resident's door in PT-A stated the sign on R29's ar a gown only when coming				

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AND DIAN OF CORRECTION \ \ \ \ IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		00844	B. WING		02/2	5/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE WA	TERVIEW SHORES LI	(:	H AVENUE BORS, MN	55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 17	21375			
	in contact with bodi					
	pathologist (SLP)-A and gloves were to resident's room on gown was only nee a resident's bodily f educated on proper corporate facility. On, 2/24/21, at 1:50 stated when cleaning	p.m. speech therapist stated eye protection, mask be worn before entering a quarantine. SLP-A stated a ded if coming into contact with luids. SLP-A stated she was PPE by a DON at another				
		ce she was not touching a d only eye protection, gloves, eeded.				
	entering a quarantii mask, gloves, and a observed the signal verified the it was in on a gown was requested with R29. Fremove the sign an R29's door. RN-B was from anther More was from anther More down and the sign and the sig	p.m. RN-B stated before ne room eye protection, a a gown were needed. RN-B ge outside R29's door and neorrect. RN-B stated putting uired when coming in close RN-B further stated she would d print the correct signage for stated the language in the sign pharch facility which had been verified the facility was not low				
	(PT)-B stated thera	m. the director of therapy py staff were to follow the ty had in place for the proper				
	indicated R39's dia	charge Report printed 2/25/21, gnoses included acute kidney compression fracture of the bra.				

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			A. BUILDING.		С	
		00844	B. WING			5/2021
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
THE WA	TERVIEW SHORES LL	C	H AVENUE BORS, MN	55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 18	21375			
	R39's admission Mi R39 had moderated dependent on staff hygiene. R39's MD indwelling catheter. On 2/24/21, at 7:39 personal cares, NA and handed it to R3 assisted R39's rem clean wash cloth an perineal area and p R39's bed. NA-H of tubing from the drai urinary tubing with a tip of leg bag tubing NA-H measured R3 drainage bag, place drainage bag in a b towel. Wearing the R39's bottom, assist the soiled towels on NA-A removed their hand hygiene, put of assisted R39 into a R39's bed, picked u into a charger, place and handed R39 his removed a garbage and put in a new ba- linens from the other chest and arm, and carried the bundle of	DS dated 2/8/21, indicated y impaired cognition and was for toileting and personal S further indicated he had an a.m. during observations of the Harmed up a wash cloth to the year of	21010			
	hallway without bag hallway floor, and c shower room and p then washed hands On 2/24/21, at 8:02	ging, dropped a towel on the arried the soiled linens to the laced in the hamper. NA-H				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
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	OLIMANA DV. OTA		BORS, MN			0.450
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21375	Continued From pa	ge 19	21375			
	infection and dropp soiled linens should to avoid contamina gloves should be cl catheter care. NA- be performed befor	room to prevent the spread of ing linens. NA-H stated to be held away from the body ting clothing. NA-H stated nanged after providing H stated hand hygiene should be putting on gloves, after the and after leaving the resident's				
	(DON) stated staff protection, a surgic isolation gown before The DON stated the wear a gown in additherapists often had residents. The DO risk for contaminati spread infection to soiled linen should body to ensure their and soiled linen should the a resident's roo disease. The DON hand hygiene shou	ip.m. the director of nursing were expected to wear eye al mask, gloves, and an are entering a quarantine room. The error of the PPE as a direct contact with the lition to the rest of the PPE as a direct contact with the lition to the rest of the preceded to lition to the rest of the PPE as a direct contact with the lition of the lition of the lition and the potential to others. The DON stated be handled away from the re was no cross-contamination ould be bagged before leaving m to prevent the spread of stated glove changes and lid be performed after catheter care to prevent cross spread of disease.				
	revised date 1/25/2 COVID-19 PPE shoresidents under obsoft N95 or higher-lever respirator is not avagoggles, and gown	foronavirus (COVID-19) 1, directed all recommended ould be worn during care of servation, which includes use wel respirator (or facemask if a ailable), eye protection, (i.e., (if facility supplies allow).				
	directed hand hygie	ene was to be completed after nt products or cleaning up				

AND DUAN OF CORRECTION IDENTIFICATION NUMBER					E SURVEY PLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW SHORES LI		H AVENUE RBORS, MN	55616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
21375	after someone who touching garbage, a and after there rem The facility policy Larevised date 10/18, laundry as potential properly bagged an processing. The pocontaminated laund be held close to the transport. Suggested Method The Director of Nurreview and revise pinfection control praperly hand hygiene lines. The DON or and perform audits being followed.	has used the toilet, after and before donning gloves, oval of gloves. aundry and Bedding, Soiled directed to handle all used lly contaminated until it is d labeled for appropriate blicy further directed all dry bags/containers are not to a body or squeezed during	21375			
21435	Recreation Program Subpart 1. General home must provide recreation program based on each indistrengths, and need meet the physical, in well-being of each is comprehensive res comprehensive pla 4658.0400 and 465	O Subp. 1 Activity and n; General al requirements. A nursing an organized activity and . The program must be vidual resident's interests, ds, and must be designed to mental, and psychological resident, as determined by the ident assessment and n of care required in parts 58.0405. Residents must be ites to participate in the	21435			3/29/21

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	
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21435	Continued From pa	ge 21	21435			
	planning and develorecreation program	opment of the activity and				
	by: Based on observati review, the facility fa activities of were pr (R27) reviewed for Findings include: R27's Transfer/Disc indicated R27 diagr infarction (stroke) a R27's significant ch (MDS) dated 1/13/2 religious activities w The MDS further independent on staff dressing, grooming personal hygiene. R27's Therapeutic I 11/13/20, indicated very religious, enjoy music, TV land and continual prompts/c process, and progra groups and church. R27's care plan dat wishes were to be i programs of interes R27's Care Area As	charge Report printed 2/25/21, noses included cerebral and palliative care. Tange Minimum Data Set 21, indicted R27's family and were very important to R27. dicated R27 was totally for bed mobility, transfers, eating, toileting, and Recreation Evaluation dated R1 had clear speech, was yed Polka and old county IME TV, required frequent or cueing to engage in group am plan was to attend small		F 679 Activities Meet Interest Immediate Corrective Action: Resident #27 and family was inter to determine activity preferences to integrate with resident □s care plant Corrective Action as it applies to on The Activity Evaluation Policy was reviewed and remained current. Activity Director and activity staff we ducated on need to interview resident/family regarding activity preferences and to integrate them resident care plan and to provide a that are meaningful to the resident All residents/families will be interviregarding activity preferences and preferences will be integrated into 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 mensure that care plan has been up on activity preferences and are be provided meaningful activities. The results will be shared with the facilic committee for input on the need to increase, decrease or discontinue audits. Corrections will be monitored by: Administrator/Social Services/Desident integrated into resident solutions.	on. thers: vill be into the activities t. ewed these the cted nonths to dated ing lie lity QAPI of the	

exhibited short and long-term memory problems

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ((X3) DATE SURVEY COMPLETED	
						
		00844	B. WING		02/2	5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW SHORES LI	C	H AVENUE	55040		
	OLIMANA DV. OTA		BORS, MN			0.5
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21435	Continued From pa	ge 22	21435			
	and staff need to an needs.	nticipate R21's wants and				
		care guide dated 2/22/21, R27's preference to attend Wednesdays.				
	stated she was uns offered to R27. FM Catholic and was verequested for staff services on Wedne would like to see R	p.m. family member (FM)-A ure what activities were being I-A stated R27 was a devoted ery religious. FM-A stated she to bring R27 to church sdays. FM-A stated she 27 get out of her room a more the human interactions even if it to go to church.				
		s on 2/23/21, at 9:06 a.m. R27 with the lights off and curtain television was on.				
	was in bed, the ligh was drawn. At 8:57 entered R27's room to drink. R27 declin her back wearing a R27 was in bed lyin or music was on. A and the church serv	ts on 2/24/21, at 7:09 a.m. R27 ts were off, and the curtain a.m. nursing assistant (NA)-H and offered R27 something ned. R27 remained lying on hospital gown. At 9:15 a.m. ag on her back. No television to 10:25 a.m. R27 was in bed, vice was scheduled to begin at f offered to bring R27 to				
		s on 2/25/21, at 8:49 a.m. R27 a hospital gown and no was on.				
	visited R27, R27 wa	6 a.m. FM-B stated when she as usually in bed. FM-B and a lot to R27 if R27 were to				

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AND BLAN OF CORRECTION (INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	C 402 - 13TH	DRESS, CITY, S H AVENUE BBORS, MN	STATE, ZIP CODE		
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21435	be able to get dress services on Wedne very spiritual, a dev wore a dress. On 2/24/21, at 1:48 not ask R27 if she we church services and seen R27 attend and was admitted. Nain bed and when off on 2/24/21, at 1:45 not get out of bed for attend Wednesday R27 would refuse to offered and preferred R27 moaned, yelled pain. On 2/25/21, at 9:38 stated activity assess admission. AD-A swere provided to reattend regular group one-on-one activities music, talking, and one-on-one visits we tried to see R27 one stated R27 was Carsomeone come in recommunion. AD-A attend Wednesday unaware if staff were to attend. AD-A stapreferred to stay in was aware religious	sed and brought to church sdays. FM-B stated R27 was oted catholic, and always of the catholic and the catholic and tried to church service since R27 of the catholic and tried to church services. NA-C stated of the catholic and was not offered to church services. NA-C stated of the catholic and would complain of the catholic and would complain of the catholic and tried to have the cat	21435			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
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		00044			02/2	5/2021
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				DEFICIENCY)		
04405	O	04	04.405			
21435	Continued From pa	ge 24	21435			
	R27's Follow Up Qu	uestion Report dated 12/27/20				
	to 2/25/21, indicted					
		g Religious Service/Bible				
		y, R27 passively participated.				
		Religious Service/Bible				
		y, R27 was not available.				
		Religious Service/Bible				
		y, R27 was not available.				
		Religious Service/Bible				
		y, R27 was not available.				
		Religious Service/Bible				
	Study/Prayer activit					
		Religious Service/Bible				
		y, R27 was not available.				
		Religious Service/Bible				
		y, R27 was not available.				
		Religious Service/Bible				
		y, R27 was not available				
	contrary to observa					
	Contrary to obcorva					
	On 2/25/21, at 1:21	n m AD-A stated				
		Not Available" could mean R27				
		d a visitor. AD-A stated the				
		item only allowed for selected				
		sen from. AD-A confirmed an				
	activity participation					
		in the Facility." The AD-A				
		to R27's Follow Up Question				
		/20 to 2/25/21, the majority of				
		ipation for Religious				
		/ Prayer was documented				
	"Resident not availa]
	1 CONCOLL HOLAVAIIC]
	On 2/25/21 at 1:17	p.m. the director of nursing				
		esident refused cares,]
		ents, staff were expected to]
		the nurse. The DON stated]
		I to re-approach a resident and				
	document the refus					
	interventions thea,	in the medical record. The				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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THE WAT	TERVIEW SHORES LI	C	HAVENUE	FFC40		
0/4) ID	CLIMMA DV CTA		BORS, MN		ON	()(5)
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21435	Continued From pa	ge 25	21435			
	to attend church sh the resident an opp Facility policy titled	ident's meaningful activity was e would expect staff to offer ortunity to attend church. Activity Evaluation undated, evaluation is conducted as				
	part of the comprehedevelop an activity and interests of the directed the resider spirituality, life roles activity pursuit patter included in the evaluation is update quarterly. SUGGESTED MET The administrator creview, and or revisensure all residents according to their creview, and crevies. The administrator creview according to their creasessment for ind activities. The administrator compliance and repassurance committed recommendations.	nensive assessment to help plan that reflects the choices resident. The policy further nt's lifelong interests, s, goals, strength, needs and erns and preferences are uation. The completed activity ed as necessary but at least THODS OF CORRECTION: or designee could develop, se policies and procedures to are invited to attend activities comprehensive activity ividualized meaningful inistrator or designee could systems to ensure ongoing port those results to the quality				
21545		O A.B.C Medication Errors	21545			3/29/21
	percent as describe Guidelines for Code 42, section 483.25 the State Operation	ist ensure that: on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of is Manual, Guidance to -Term Care Facilities, which is				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			71. BOILDING.			,	
		00844	B. WING			5/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE WA	TERVIEW SHORES LI	C	H AVENUE BORS, MN	55616			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21545	incorporated by refepurposes of this pa (1) a discrepant prescribed and what administered to rescribed and incomplete (2) the administered to rescribed. An incomplete (1) an error of the control of th	erence in part 4658.1315. For rt, a medication error means: ncy between what was at medications are actually idents in the nursing home; or stration of expired any significant medication medication error is: which causes the resident ardizes the resident's health or on from a category that usually ation in the resident's blood to be compared as a single and a single and alter that level and alter that level and alter earlier or medication error goifficant medication error goifficant medication error goifficant medication error and the dent's legal guardian or entative and an explanation er esident's clinical record. One are administered as dent report or medication error that cant medication errors or must be reported to the explanation error that cant medication errors or must be reported to the explanation error that cant medication errors or must be reported to the explanation error that cant medication errors or must be reported to the explanation error that cant medication errors or must be reported to the explanation error that cant medication errors or must be reported to the explanation error that cant medication errors or must be reported to the explanation error that cant medication errors or must be reported to the explanation error that cant medication errors or must be reported to the explanation error that cant medication errors or must be reported to the explanation error that cant medication errors or must be reported to the explanation error that errors or must be reported to the explanation error that errors or must be reported to the explanation error that errors or must be reported to the explanation error that errors or must be reported to the explanation error that errors or	21545				
	This MN Requirement by:	ent is not met as evidenced					

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMPI			
		00844	B. WING		02/2	; 5/2021		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE				
THE WA	TERVIEW SHORES LI	C	H AVENUE BORS, MN	55616				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
21545	Continued From pa	ge 27	21545					
	Based on observation review, the facility for were not crush and administered togeth and evaluation, to program for 3 of 6 residents medication administered togeth and evaluation, and the series of	ion, interview, and document ailed to ensure medications mixed together (cocktail) or ner without physician orders prevent adverse interactions (R31, R36, R28) reviewed for stration. Charge Report dated 2/24/21, gnoses included dementia disturbance, myasthenia gravis ses weakness in voluntary nuscles for swallowing), and interest in the second of th		F 759 Free of Medication Error >5 Immediate Corrective Action: Nurse involved was immediately on that cocktailing of meds is not appropriate unless there is a speciorder. Corrective Action as it applies to on The Administering Medications the Enteral Tube Policy was reviewed remained current. All nurses/TMAs were educated the cocktailing (mixing) of medications appropriate for residents who have feeding unless there is an MD ordeducated that medications can to crushed and mixed together unless is an MD order. All residents who receive medicatifeeding tube or require crushed medications will have MD notified determine whether crushing and/of medications is appropriate for the 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 nensure that any resident who receive medications or medication through a PEG tube are administer individually unless there is an MD that it is ok to mix and administer individually unless there is an MD that it is ok to mix and administer individually unless there is an MD that it is ok to mix and administer individually unless there is an MD that it is ok to mix and administer individually unless there is an MD that it is ok to mix and administer individually unless there is an MD that it is ok to mix and administer individually unless there is an MD that it is ok to mix and administer individually unless there is an MD that it is ok to mix and administer individually unless there is an MD that it is ok to mix and administer individually unless there is an MD that it is ok to mix and administer individually unless there is an MD that it is ok to mix and administer individually unless there is an MD that it is ok to mix and administer individually unless there is an MD that it is ok to mix and administer individually unless there is an MD that it is ok to mix and administer individually unless there is an MD that it is ok to mix and administer individually unless there is an MD that it is ok to mix	ducated ific MD thers: rough an and nat is is not e a tube er. Also, be sthere ons via to or mixing nat cted nonths to ives ns red order together. facility eed to			

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED	
		A. BUILDING:				
	00844	B. WING		02/2	02/25/2021	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
THE WATERVIEW SHORES LLC	402 - 13Th	AVENUE				
THE WATERVIEW SHORES LEG	TWO HAR	BORS, MN	55616			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
(LPN)-B was observed medications for admitincluded Tylenol, Pyry gabapentin. LPN-B pand Motrin into a smathem together. LPN-an order for crushing said she could not put computer. LPN-B stadiet, so it was OK to together. LPN-B commedications together sauce, and added the capsule into the application administered the merpersuading, R31 tool prepared. R36's Transfer/Dischindicated R36's diagradisease, congestive (irregular heart rhythmalnutrition, and dysidifficulties). R36's Order Summa of 2/24/21, included of donepezil; give 10 more related to Alzheimer's retoprolol succinate hour; give 25 mg by bedtime related to comirtazapine tablet; give 10 mirtazapine tablet; give 10 mirtazapine tablet; give 10 mirtazapine tablet; give 25 mg by the second control of table	o.m. licensed practical nurse ed preparing R31's inistration. Medications idostigmine, Motrin, and put Tylenol, Pyridostigmine all plastic bag, and crushed -B stated R31 should have g medications in the TAR, and all up the orders on her ated R31 was on a pureed crush her medications intinued to crush the r, mixed them with apple e uncrushed gabapentin le sauce. LPN-B then dications to R31, and after k her medications as harge Report dated 2/24/21, noses included Alzheimer's heart failure, atrial fibrillation m), moderate protein-calorie sphagia (swallowing ary Report for active orders as orders for: ng by mouth at bedtime s disease e extended release (ER) 24 mouth every morning and at ongestive heart failure give 15 mg by mouth at oderate protein-calorie	21545				

Minnesota Department of Health

STATE FORM DWRM11 If continuation sheet 29 of 36

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7t. BOILDING.			:
		00844	B. WING			5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW SHORES L	1 C	H AVENUE RBORS, MN	55616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21545	Continued From pa	age 29	21545			
	lacked directives to	o cocktail crushed medications n medications could be				
	related to dysphagi directions to cockta	1, directed to crush eed consistency every shift ia. R36's MAR lacked ail crushed medications medications could be				
	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.					
	indicated R28's dia atherosclerotic hea and narrowing of you major depressive d D deficiency, const gastro-esophageal	reflux disease (GERD-when lently flows back into the tube				
	of 2/24/21, included -aspirin tablet chew morning related to -calcium carbonate	nary Report for active orders as d orders for: vable; give 81 mg in the chronic atrial fibrillation at tablet 600 mg; give 600 mg in d to age-related osteoporosis				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				LETED
					ے ا	
		00844	B. WING		02/2	, 5/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
		402 - 13TH	AVENUE			
THE WA	TERVIEW SHORES LL	C	BORS, MN	55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21545	Continued From pa	ge 30	21545			
21545	-cholecalciferol cap morning related to a-isosorbide mononing morning and at bed-Lipitor tablet 40 mg related to hyperlipid morning for suppler -Norco tablet 5-325 morning and at bed -Norvasc; give 5 mg essential hypertens -Protonix Tablet del tablet in the morning tablet in the morning for constip -Zoloft Tablet; give to major depressive -NPO diet (nothing -Medications have to through PEG tube (gastrostomy tube pfor enteral feeding, administration) with between. DO NOT TOGETHER, order R28's MAR for 2/21 one at a time through water flushes in bet ADMINISTER MED On 2/24/21, at 7:38 was observed preparadministration. RN into two medication	sule give 1000 units in the age-related osteoporosis trate tablet; give 30 mg every time related to ASHD g; give 40 mg in the morning emia ablet; give one table in the ment mg; give 1 tablet every time for chronic back pain g in the morning related to ion ayed release 40 mg; give one g for dissolve and mix in one ed to GERD 6-50 mg; give one tablet in the ation 100 mg in the morning related e disorder by mouth) to be given one at a time percutaneous endoscopic lace directly into the stomach hydration and medication small water flushes in ADMINISTER MEDICATIONS date 4/6/20. I directed to give medications gh the PEG tube with small ween. DO NOT INCATIONS TOGETHER. a.m. registered nurse (RN)-A aring R28's medications for -A dispensed the medications cups together, and started to	21545			
	-Zoloft Tablet; give to major depressive -NPO diet (nothing -Medications have t through PEG tube (gastrostomy tube p for enteral feeding, administration) with between. DO NOT TOGETHER, order R28's MAR for 2/21 one at a time throug water flushes in bet ADMINISTER MED	100 mg in the morning related e disorder by mouth) to be given one at a time percutaneous endoscopic lace directly into the stomach hydration and medication small water flushes in ADMINISTER MEDICATIONS date 4/6/20. , directed to give medications gh the PEG tube with small ween. DO NOT IICATIONS TOGETHER.				
	was observed preparadministration. RN into two medication take a plastic bag to	aring R28's medications for -A dispensed the medications				

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together, RN-A stopped and said she should

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COIVIP	LETED
		00844	B. WING			5/2021
NAME OF I		CTDEET AD	DDECC CITY (STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE WATERVIEW SHORES LLC			H AVENUE	FF040		
		TWO HAR	BORS, MN	55616		
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
21545	Continued From pa	ge 31	21545			
21040			21040			
		a time, but said she usually				
		hem together. RN-A stated				
		rs to do one medication at a				
		d to crush each medication				
		them in separate medication				
		the crushed medications to				
		ter checking R28's PEG tube				
		shing 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					
		m each cup into R28's PEG				
		another without flushing				
		ication. RN-A stated R28 did				
	not have orders to f	flush between each				
	medication, but her	orders said to give one at a				
	time.	-				
		p.m. the director of nursing				
	,	wed and stated R28's				
		be crushed individually and				
		dually, and verified R28's MAR				
		ch medication individually				
		. The DON stated they follow when residents are admitted				
		it says do not crush, and put it				
		ON stated otherwise it was				
		as they have it on their				
		ie DON stated they get an				
		sician to crush medications.				
		ed the pharmacist reviewed				
		dicated if they need to be				
	separated.	-				
		0 p.m. the consultant				
		stated medications should not				
		n crushed, because you just				
		nd of interactions they may				
		the nursing staff should get an				
	order to crush and l	have the pharmacist review for				

Minnesota Department of Health

STATE FORM DWRM11 If continuation sheet 32 of 36

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.			
		00844	B. WING		1	5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WA	TERVIEW SHORES L	C	H AVENUE RBORS, MN	55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21545	CP-A stated they slextended-release in get the proper effect stated they have rebe crushed, and veradministered separabetween each medications, and remedications, and remedication observed CP-A stated he word crushing. The facility policy C4/18, directed the inwould identify approprocedures for crushing or physician to crush a manufacturer advisorushed, such as low medication. The policy formust identify and dosage form, documedications will no provide justification modification will no and the nursing stapertinent adverse eindicate why it is not the policy further of crushed separately and addressed that separately may not the facility policy A through an Enteral	ailing crushed medications. hould not be crushing hedication, as they would not et from the medication. CP-A viewed R28's medications to rified they should be rately and have a water flush ication. CP-A stated he had residents for crushing eviewed R31 and R36's ed to be crushed at this time. alld review their medications for crushing Medications revised hedical director, DON and CP opriate indications and shing medications, and CP to notify the ordering a medication when the hed a medication should not be ong-acting or enteric coated blicy directed the physician or halternative medication and/or ment why crushing t adversely affect the resident, why the dosage form t compromise the resident, ff will observe the resident for effects. The MAR must ecessary to crush medications. Iirected medications should be and administered with food, t sometimes giving them be appropriate for a resident. dministering Medications Tube revised 11/18, directed	21545			
	through an Enteral nursing to administ	•				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED	
,	0. 00.11.120.10.1		A. BUILDING:				
		00844	B. WING	B. WING		C 02/25/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE WA	TERVIEW SHORES LI	C	H AVENUE BORS, MN	EEC1C			
040.15	CLIMMA DV CTA		-		DNI .	045)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21545	Continued From page 33		21545				
	Medication List" wit	t on the "Do Not Crush th the pharmacy. The policy lush with 15 ml water between					
	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 (21) days.	R CORRECTION: Twenty-one					
21620	MN Rule 4658.134	5 Labeling of Drugs	21620			3/29/21	
	Drugs used in the r in accordance with	nursing home must be labeled part 6800.6300.					
	This MN Requirement	ent is not met as evidenced					
	review, the facility for medications for	ion, interview, and document ailed to ensure proper labeling 1 of 6 residents (R28) ation administration.		F 761 Label/Store Drugs and Biolo Immediate Corrective Action: Resident #28□s medication card vupdated to reflect the current			
	indicated R28's dia atherosclerotic hea and narrowing of yo	charge Report dated 2/24/21, gnoses included osteoporosis, rt disease (ASHD- hardening our arteries), heart failure, isorder, chronic pain, vitamin		dosage/instructions. Corrective Action as it applies to of The Labeling of Medications Policy reviewed and remained current. All nurses/TMAs were educated or need to ensure that their medication match the order before administer medication(s).	y was n the on cards		

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					c	;
		00844	B. WING		02/2	5/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THF WA	TERVIEW SHORES LL	C	AVENUE			
		TWO HAR	BORS, MN	55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21620	Continued From pa	ge 34	21620			
	stomach acid frequence connecting the mound of 2/24/21, included calcium carbonate the morning related order date 4/6/20. Norco tablet 5-325 morning and at bed order date 4/6/20. Medications have to through PEG tube (gastrostomy tube programmer or enteral feeding, administration) with	reflux disease (GERD-when ently flows back into the tube of the and stomach). ary Report for active orders as a orders for: tablet 600 mg; give 600 mg in to age-related osteoporosis, mg; give 1 tablet every time for chronic back pain, to be given one at a time percutaneous endoscopic lace directly into the stomach hydration and medication small water flushes in ADMINISTER MEDICATIONS		All residents ☐ medication cards we reviewed to ensure that medication match the current orders. If they depend on the current orders is they depend on the current orders is to notify nurse/TMA of a medication change and to check chart and phase 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 mensure that the medication cards in the current orders. The results will shared with the facility QAPI comminput on the need to increase, decidiscontinue the audits. Corrections will be monitored by: DON/NM/Designee	n cards on □t the card on armacy cted nonths to match be nittee for	
	was observed prepadministration. RN administer to R28. milligram (mg) table a medication cup. I compared it with the Record (MAR) and was to receive one the pharmacy sent she would call the pthe resident receive dosage. When as the label did not maput stickers on the check the medicatic would call the pharm bottle indicated R28	a.m. registered nurse (RN)-A aring R28's medications for A prepared medications to RN-A dispensed one 500 et of Oyster Shell Calcium into RN-A read the label and Medication Administration stated R28's MAR stated R28 600 mg tablet of calcium, but the 500 mg tablets. RN-A said physician to notify them that ed the wrong medication ked what she would do when atch the orders, she said they medication to alert nursing to on orders. RN-A stated she macy, also. R28's medication by bottle of calcium had been macy on 2/20/21, and had				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00844	B. WING		02/2	5/2021
	PROVIDER OR SUPPLIER	C 402 - 13TI	H AVENUE	STATE, ZIP CODE	•	
	TERVIEW ONOREO EL	TWO HAR	BORS, MN	55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21620	contained 30 tablets remaining tablets, a after she had dispe of the wrong dose hadministered. RN-500 mg tablet, since prescribed dose, are addition, R28's Nor administer one tablepain. R28's orders scheduled for twice received new order. On 2/24/21, at 2:45 (DON) verified med the orders, and the they did not match. The facility policy Late 12/19, directed all new would be properly a current state and few would inform the physician orders for SUGGESTED MET. The Director of Nurdevelop, review, an procedures to ensulabeled with an app. The DON or design appropriate staff on The DON or design systems to ensure of the sure o	s. RN-A counted the and indicated 27 had remained nsed one, indicating 2 tablets had been previously A stated she would give the e it was less than the hid then notify the physician. In co 5-325 mg label read to et twice daily as needed for indicated R28's Norco was a daily. RN-A stated R28 had s. p.m. the director of nursing lication labels should match pharmacy should be notified if abeling of Medications dated nedications in the facility abeled in accordance with the ederal regulations, and nursing narmacy of any changes in	21620			

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Minnesota Department of Health STATE FORM

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PRINTED: 03/23/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING		(X3) DATE SURVEY COMPLETED		
		245471	B. WING			02/24/2021	
	PROVIDER OR SUPPLIER	_C		4	STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE TWO HARBORS, MN 55616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 COMMENT	rs	K 0	000			
	FIRE SAFETY						
	Minnesota Departm Fire Marshal Division The Waterview Sho compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, ores LLC was found not in requirements for participation and at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), g Health Care.					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.					
	ONSITE REVISIT (CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
		E AN EPOC, A PAPER COPY CORRECTION IS NOT					
	PLEASE RETURN CORRECTION FOI DEFICIENCIES (K	R THE FIRE SAFETY					
	/ DIDECTOR'S OR DROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATLIDE		TITI F		(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.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 245471 B. WING 02/24/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **402 - 13TH AVENUE** THE WATERVIEW SHORES LLC TWO HARBORS, MN 55616 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 000 Continued From page 1 K 000 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

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THE WAT	TERVIEW SHORES L	LC			02 - 13TH AVENUE		
				T	WO HARBORS, MN 55616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 901	Continued From pa This deficient cond Maintenance Supe	ition was confirmed by a	K 9	01	Corrections monitored by: Corrections monitored by Maintenance Direction and Administrator of Record		