Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 18, 2025

Administrator
The Waterview Woods LLC
601 GRANT AVENUE
EVELETH, MN 55734

RE: CCN: 245277
Cycle Start Date: July 25, 2025

Dear Administrator:

On August 19, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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September 18, 2025

Administrator
The Waterview Woods LLC
601 GRANT AVENUE
EVELETH, MN 55734

Re: Reinspection Results
Event ID: 1D1E93-H2

Dear Administrator:

On August 19, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on 07/25/2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

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Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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Saint Paul, MN 55164-0900
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An equal opportunity employer.

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Electronically delivered

July 31, 2025

Administrator

The Waterview Woods LLC
601 GRANT AVENUE
EVELETH, MN 55734

RE: CCN:245277
Cycle Start Date: July 25, 2025

Dear Administrator:

On July 25, 2025, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by October 25, 2025(three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified byJanuary 25, 2026(six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will

not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

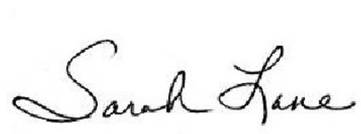
INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterview Woods LLC	601 GRANT AVENUE , EVELETH, Minnesota, 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 7/24/25, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The following complaints were reviewed: H52771006C (MN2566957) with a deficiency cited at F584, F760. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F0584	Immediate Corrective Action: Towel removed and ceiling tile replaced. Corrective Action as it applies to others: Resident rights reviewed. All resident rooms have been evaluated to ensure they have a safe, clean, comfortable and homelike environment. Maintenance director will be educated on following the resident rights regarding a safe and clean environment. Recurrence will be prevented by:	08/08/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025

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F0584 SS = D	Continued from page 1 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure ceiling tiles were maintained in a safe manner for 1 of 1 resident (R49) reviewed for environment. Findings include: R49's quarterly Minimum Data Set (MDS) dated 5/13/25, identified intact cognition. Diagnoses included hypertension, hyperlipidemia and renal insufficiency. During observation on 7/24/25 at 11:08 a.m. R3's bathroom had a missing ceiling tile that was over the toilet. There was a wet towel draped across the hole and drooping down, exposing the area above the ceiling tiles. There was noted free standing water on the toilet itself. The white towel was stained with brown discoloration along with the middle areas saturated with moisture. During an interview on 7/24/25 at 11:10 a.m. R3 stated	F0584	Continued from page 1 5 residents rooms will be evaluated to ensure they are clean, safe, and free of wet or stained towels/ceiling tiles. This will occur weekly x4 weeks then monthly times 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Administrator or Designee	

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The Waterview Woods LLC	601 GRANT AVENUE , EVELETH, Minnesota, 55734

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F0584 SS = D	Continued from page 2 the ceiling tile has been missing and the towel in place for at least a month. He was told it was because of a leak of some kind from the room on the second floor, right above R3's room. During an interview on 7/24/25 at 12:18 p.m., housekeeper (HSK)-A stated the missing ceiling tile and towel over the tile has been that way for at least a month. There was some kind of leak in the room above this. It must still be leaking because when the room was cleaned this morning there was free standing water and the toilet paper on the back of the toilet had to be thrown away because it was soaked with water. During an interview on 7/24/25 at 1:28 p.m., the maintenance director (M)-A stated he was not sure how long the ceiling tile had been that way in R3's room. There was a leak in the toilet ion the room above R3's room and that is where the water had come from. The leak had been fixed, and the towel was there to see if the leak was still there. During an interview on 7/24/25 at 12:40 p.m., the infection preventionist (IP) stated anytime wet towels were left hanging in rooms and there was free standing water in the room there was an increased risk of infection and other illnesses to be present. During an interview on 7/24/25 at 2:06 p.m., the regional director of operations (RDO) stated water leakage, and a damaged ceiling would lead to the resident being moved, water cleaned up, and the problem fixed prior to letting any resident back in the room. A policy for environmental services water leakage was requested but not provided.	F0584		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure accurate doses of buprenorphine (an opioid pain medication) were administered to 1 of 3 residents (R1) investigated for a significant medication error.	F0760	Immediate Corrective Action: Nurses educated on Medication Administration Policy. Corrective Action as it applies to others: Medication Administration-General Guidelines policy was reviewed and remains current. All residents that have specific medication administration instructions reviewed and adjusted to ensure residents receive medications with the proper dose.	08/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025

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F0760 SS = D	Continued from page 3 Findings include: R1's face sheet dated 7/24/25 indicated diagnoses included pathological fracture in neoplastic disease of left femur (left leg upper bone), malignant neoplasm of esophagus and aftercare for joint replacement. R1's medical record indicated R2 was cognitively intact. R1's physician orders dated 7/16/25, indicated an order for buprenorphine HCL sublingual 2mg tablet. Give 1mg (half a tab) under tongue three times a day. A picture of R1's medication card dated 7/16/25, showed an individual bubble packed 30-day card with 24 whole pills, one in each bubble. There were also 6 slots with holes to indicate 6 pills had been removed. The order on the card identified buprenorphine sub. 2 milligrams (mg). Place half a tab under tongue three times a day. Pharmacy to send full 2mg tablets. Nursing to cut to administer 1mg three times a day. R1's narcotic sign-out book page not dated, indicated an order of buprenorphine 2mg give half a tablet three times a day. The page indicated on 6 different occasions R1 received a whole tablet instead of the half tablet ordered. During an interview on 7/24/25 at 1:05 p.m., licensed practical nurse (LPN)-A stated if a whole pill was signed out there would be a dot with a line under it. If there was a half a tablet removed there would be "1/2 tab" document in amount given and then a note which would indicate if the other half was thrown away or saved for the next dose. LPN-A reviewed R1's narcotic medication sign out sheet and stated the documentation showed R1 received one whole tablet each time a dose was given. During an interview on 7/24/25 at 1:44 p.m. the acting director of nursing (DON) stated nursing needed to follow the five rights (right medication, patient, dose, route and time). A half tablet should be documented as "1/2" and a whole tablet given would be documented as a dot with a line under it. Facility policy Medication Administration- General Guidelines last reviewed 2025, indicated nursing would follow the five rights and would triple check those rights during the medication administration process.	F0760	Continued from page 3 All nurses will be educated on following medication administration orders and medication dosing. Recurrence will be prevented by: 5 residents medication administration will be audited to ensure proper dose and time related to the physician order. This will occur weekly x4 weeks then monthly times 2 months. The results of the audits will be shared with the facility QAPI committee for input in the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Director of Nursing or Designee	

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Electronically delivered

July 31, 2025

Administrator
The Waterview Woods LLC
601 GRANT AVENUE
EVELETH, MN 55734

Re: State Nursing Home Licensing Orders
Event ID: 1D1E93-H1

Dear Administrator:

The above facility was surveyed on July 25, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

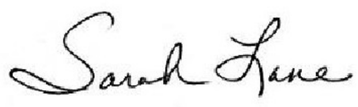
Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
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P.O. Box 64900
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/25/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterview Woods LLC	**601 GRANT AVENUE , EVELETH, Minnesota, 55734**

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/24/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/25/2025**

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20000	Continued from page 1 The following complaints were reviewed: H52771006C (MN2566957) with a licensing order issued at 21545, 21695. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
21545	Medication Errors CFR(s): MN Rule 4658.1320 A.B.C A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m),	21545	corrected	08/08/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterview Woods LLC	**601 GRANT AVENUE , EVELETH, Minnesota, 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
21545	Continued from page 2 found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure accurate doses of buprenorphine (an opioid pain medication) were administered to 1 of 3 residents (R1) investigated for a significant medication error. Findings include: R1’s face sheet dated 7/24/25 indicated diagnoses included pathological fracture in neoplastic disease of left femur (left leg upper bone), malignant neoplasm of	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/25/2025**

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21545	Continued from page 3 esophagus and aftercare for joint replacement. R1's medical record indicated R2 was cognitively intact. R1's physician orders dated 7/16/25, indicated an order for buprenorphine HCL sublingual 2mg tablet. Give 1mg (half a tab) under tongue three times a day. A picture of R1's medication card dated 7/16/25, showed an individual bubble packed 30-day card with 24 whole pills, one in each bubble. There were also 6 slots with holes to indicate 6 pills had been removed. The order on the card identified buprenorphine sub. 2 milligrams (mg). Place half a tab under tongue three times a day. Pharmacy to send full 2mg tablets. Nursing to cut to administer 1mg three times a day. R1's narcotic sign-out book page not dated, indicated an order of buprenorphine 2mg give half a tablet three times a day. The page indicated on 6 different occasions R1 received a whole tablet instead of the half tablet ordered. During an interview on 7/24/25 at 1:05 p.m., licensed practical nurse (LPN)-A stated if a whole pill was signed out there would be a dot with a line under it. If there was a half a tablet removed there would be "1/2 tab" document in amount given and then a note which would indicate if the other half was thrown away or saved for the next dose. LPN-A reviewed R1's narcotic medication sign out sheet and stated the documentation showed R1 received one whole tablet each time a dose was given. During an interview on 7/24/25 at 1:44 p.m. the acting director of nursing (DON) stated nursing needed to follow the five rights (right medication, patient, dose, route and time). A half tablet should be documented as "1/2" and a whole tablet given would be documented as a dot with a line under it. Facility policy Medication Administration- General Guidelines last reviewed 2025, indicated nursing would follow the five rights and would triple check those rights during the medication administration process. SUGGESTED METHOD OF CORRECTION: The DON could review and revise policies and procedures. Nursing staff could be educated as necessary to the importance of properly administrating medications. The DON or designee could conduct audits on a regular basis to ensure compliance.	21545		

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21545	Continued from page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		
21695	Plant Housekeeping, Operation, & Maintenance CFR(s): MN Rule 4658.1415 Subp. 4 Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure ceiling tiles were maintained in a safe manner for 1 of 1 resident (R49) reviewed for environment. Findings include: R49's quarterly Minimum Data Set (MDS) dated 5/13/25, identified intact cognition. Diagnoses included hypertension, hyperlipidemia and renal insufficiency. During observation on 7/24/25 at 11:08 a.m. R3’s bathroom had a missing ceiling tile that was over the toilet. There was a wet towel draped across the hole and drooping down, exposing the area above the ceiling tiles. There was noted free standing water on the toilet itself. The white towel was stained with brown discoloration along with the middle areas saturated with moisture. During an interview on 7/24/25 at 11:10 a.m. R3 stated the ceiling tile has been missing and the towel in place for at least a month. He was told it was because of a leak of some kind from the room on the second floor, right above R3’s room. During an interview on 7/24/25 at 12:18 p.m., housekeeper (HSK)-A stated the missing ceiling tile and towel over the tile has been that way for at least a month. There was some kind of leak in the room above this. It must still be leaking because when the room was cleaned this morning there was free standing water and the toilet paper on the back of the toilet had to be thrown away because it was soaked with water. During an interview on 7/24/25 at 1:28 p.m., the maintenance director (M)-A stated he was not sure how long the ceiling tile had been that way in R3’s room. There was a leak in the toilet ion the room above R3's room and that is where the water had come from. The	21695	corrected	08/08/2025

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21695	Continued from page 5 leak had been fixed, and the towel was there to see if the leak was still there. During an interview on 7/24/25 at 12:40 p.m., the infection preventionist (IP) stated anytime wet towels were left hanging in rooms and there was free standing water in the room there was an increased risk of infection and other illnesses to be present. During an interview on 7/24/25 at 2:06 p.m., the regional director of operations (RDO) stated water leakage, and a damaged ceiling would lead to the resident being moved, water cleaned up, and the problem fixed prior to letting any resident back in the room. A policy for environmental services water leakage was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator, Director of Nursing (DON), or designee could develop, review, and/or revise policies and procedures, educate all appropriate staff on the policies and procedures, and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		