Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 21, 2025

Administrator
The Waterview Pines LLC
1201 8TH STREET SOUTH
PO BOX 971
VIRGINIA, MN 55792

RE: CCN: 245283

Cycle Start Date: July 24, 2025

Dear Administrator:

On August 28, 2025, we notified you a remedy was imposed. On September 23, 2025, 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 September 02, 2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective September 12, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of August 28, 2025, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 12, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308   Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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November 21, 2025

Administrator
The Waterview Pines LLC
1201 8TH STREET SOUTH
PO BOX 971
VIRGINIA, MN 55792

Re: Reinspection Results
Event ID: 1D1E95-H2

Dear Administrator:

On August 22, 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 07/24/2025. At this time these correction orders were found corrected.

Please feel free to call me with any 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

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 1, 2025

Administrator
The Waterview Pines LLC
1201 8TH STREET SOUTH
PO BOX 971
VIRGINIA, MN 55792

RE: CCN:245283

Cycle Start Date: July 24, 2025

Dear Administrator:

On July 24, 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 24, 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 24, 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

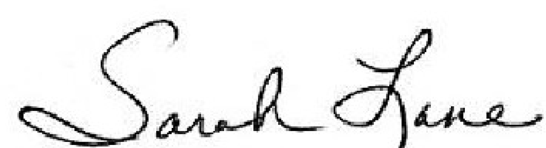
INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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,



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

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Electronically delivered
August 1, 2025

Administrator
The Waterview Pines LLC
1201 8TH STREET SOUTH
PO BOX 971
VIRGINIA, MN 55792

Re: State Nursing Home Licensing Orders
Event ID: 1D1E95-H1

Dear Administrator:

The above facility was surveyed on July 24, 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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
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

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterview Pines LLC	**1201 8TH STREET SOUTH PO BOX 971, VIRGINIA, Minnesota, 55792**

(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, an abbreviated survey was completed by surveyors from the Minnesota Department of Health (MDH) to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H52839648C (2562308); incidental non-compliance cited at F585. 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		08/08/2025
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F0585	Immediate Corrective Action: Grievances filed per Complaint and Grievance Policy. Corrective Action as it applies to others: Complaint and Grievance policy reviewed. All cognitive residents were interviewed to report any complaints and grievances. All non-cognitive residents' responsible representatives contacted to report any complaints and grievances. All resident complaints and grievances will be filed, investigated, and followed up on per policy.	08/14/2025

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: 245283	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

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F0585 SS = D	Continued from page 1 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions	F0585	Continued from page 1 All staff will be educated on complaints and grievances. Recurrence will be prevented by: 5 residents or responsible representatives will be interviewed to report any complaints and grievances weekly x4 weeks then monthly x2. These results will be shared with the facility QAPI committee to increase, decrease or discontinue audits. Corrections will be monitored by: Administrator or Designee	

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F0585 SS = D	Continued from page 2 include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure voiced concerns about the provision of care were acted upon timely and resolved to help potentially prevent occurrences for 3 of 3 residents (R1, R4, R6) reviewed who had voiced concerns about care from a staff member. Findings include: A facility-reported Vulnerable Adult Maltreatment Report (i.e,, FRI) dated, 7/16/25, identified R1 reported being handled roughly by a nursing assistant (NA) the night prior. The report identified NA-A as the alleged perpetrator and outlined they had been terminated from the care center. The report continued and identified another resident (R6) had reported concerns about how NA-A had transferred them and, again, that NA-A was rough with cares. R1's admission Minimum Data Set (MDS), dated 6/19/25, identified R1 had moderate cognitive impairment but demonstrated no delusional thinking. On 7/24/25 at 11:27 a.m., R1 was interviewed and recalled the incident from the week prior. R1 expressed it involved a male staff member who she felt was rough when doing cares. R1 stated she was sleeping at night and then suddenly, "Next thing I knew, I was against the wall." R1 stated the male staff member just rolled her over without waking her up which caused her to be startled	F0585		

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The Waterview Pines LLC	1201 8TH STREET SOUTH PO BOX 971, VIRGINIA, Minnesota, 55792

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F0585 SS = D	Continued from page 3 and have some pain. R1 stated being moved by him without warning was upsetting adding aloud, "It was too hard [how he moved her]." R1 stated she reported this concern to someone at the care center but was unsure whom. R1's Aeris History & Physical, dated 7/14/25, identified R1 was evaluated by the medical doctor (MD) who outlined, "Patient' neurostatus [sic] has not changed but she does claim there was some roughness with her last night ... claims that somebody beat her up at this time but it is vague ... gave to social service director [ ] and they are going to investigate. No reported injury noted last evening but she does have palpatory tenderness ... will do an x-ray at this time." When interviewed on 7/24/25 at 12:13 p.m., NA-B stated they had worked at the campus through their agency for "approximately three or four months." NA-B stated they were aware R1 had reported "someone had rough handled her," and verified they had worked the shift with NA-A on the date of the alleged incident. NA-B stated they had never physically seen NA-A be intentionally abusive to any residents, however, had reported some concerns prior about his care to other staff members. NA-B stated "the resident's" had reported concerns that NA-A would "move too fast" with cares and, as a result, NA-B had told NA-A he needed to "slow down" while providing care. At 12:52 p.m., a follow-up interview was completed with NA-B. NA-B explained they had first heard residents' concerns being expressed about NA-A "as soon as I came here" and started working several months prior. NA-B reiterated the comments by the residents started at the same time and expressed they felt it was already being addressed from appearances. NA-B stated several residents had complained about NA-A and his provided care and named R4. NA-B stated residents' comments were often about NA-A moving "too fast" and explained there had also been one incident where a resident who used a mechanical lift was left suspended up while NA-A left the room to get incontinence products which NA-B attributed to a lack of organization with cares and a need for additional training. NA-B stated NA-A could be "not easy to talk to" and help improve his cares as he seemed to "take is sometimes personally." NA-B stated they felt the management was aware of these concerns, including from months' prior, as "the charge nurse" who often worked as aware of the concerns, too. NA-B stated multiple nurses who had worked with NA-A also, "Say the same thing." NA-B reiterated the employee all of these concerns had been reported and/or observed with was NA-A.	F0585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245283**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/24/2025**

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F0585 SS = D	Continued from page 4 R4's quarterly Minimum Data Set (MDS), dated 6/8/25, identified R4 had moderate cognitive impairment but demonstrated no delusional thinking. On 7/24/25 at 2:20 p.m., R4 was interviewed about his services in the nursing home and responded aloud, "Not great." R4 was questioned if he had any concerns about the care provided by NA-A he could recall to which R4 responded aloud, "[NA-A] I had trouble with." R4 explained NA-A had never physically hurt him but rather just "comes on strong" and did not always explain cares or what he wanted adding, "It's a demand thing by him." R4 added, "I don't like that." R4 stated he had told the staff at the desk about these concerns but was dismissed with a "boys will be boys" response. R6 was discharged from the care center at the time of survey and unavailable for interview. During the abbreviated survey, a telephone interview was attempted with NA-A; however, they were unable to be reached. When interviewed on 7/24/25 at 1:43 p.m., licensed practical nurse (LPN)-A verified they routinely worked the overnight shift and had worked with NA-A. LPN-A stated they had never observed or had anyone report concerns about NA-A's care on the night shift prior adding, "He was one of the nicest guys there ever was." The facility-provided WVP (Waterview Pines) Grievances listing, dated 1/1/25 to 7/25/25, identified all filed grievances along with each' respective incident number, category, resident involved, date reported and resolution date. The listing identified R4 had filed a grievance in April 2025 related to call light response; however, the listing outlined no grievances were filed for R1, R4, R5 related to provision of care concerns. The provided listing lacked employee name details. During the abbreviated survey, no evidence was provided to demonstrate the facility' had acted upon the concerns expressed by residents to NA-B until 7/7/25 when a FRI for R4 was submitted; despite other staff hearing concerns from the residents about NA-A's provided care for several months prior. On 7/24/25 at 3:14 p.m., the administrator, director of nursing (DON), and social worker (SW)-A were interviewed, and SW-A verified they helped address and manage grievances for the resident population. The administrator stated they were aware of "the two situations" which had a VA filed (i.e., R4, R1) about them and upon completing an investigation into those	F0585		

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F0585 SS = D	Continued from page 5 learned of R6 having concerns about NA-A's provided care. The administrator stated none of the staff had raised concerns about NA-A's care prior to those events adding, "Nobody has brought up any concerns." The administrator stated they had an "all staff" meeting recently, too, and nothing was voiced or raised about the NA's care. The administrator and DON both verified they were unaware of an incident involving a resident being left suspended in the air in a mechanical lift until now with the administrator adding, "This is news to me." The administrator and DON both expressed they would have immediately followed up on that concern if it had been reported to them. The management team all acknowledged they had not been told of the concerns as heard by the floor staff and were unaware of any concerns until 7/7/25, when the first FRI for R4 was submitted. The DON and administrator both acknowledged having completed no formal audits of NA-A's care including after 7/7/25, when the FRI was reported. The team all expressed a formal grievance would have likely been completed months prior if they had been told of the concerns with NA-A's care; and the administrator stated they would have acted upon it earlier (prior to 7/7/25) had the information reached them adding, "I absolutely would have [followed up]." The administrator stated no formal grievances were filed on the FRI(s) as they were reportable to the State agency; however, the administrator expressed it was important to ensure concerns were addressed and resolved timely "so it doesn't happen to the next person," adding further, "Little concerns can turn into something big if it's not addressed." Further, the administrator stated they felt having the new management at the care center and more frequent "all staff" meetings would help ensure concerns get reported more timely to them from the floor staff. A facility' provided Complaint and Grievance Policy, dated 9/2023, identified any resident could file a grievance and forms were readily available within the care center adding, "Any complaints, regardless of how they are received by the facility, will be investigated per the policy." The policy continued, "A grievance form should be completed when a complaint has been give to any employee of the facility. This includes when a grievance has been resolved right away to show documentation that it was addressed and resolved to the satisfaction of the person submitting the concern." The policy directed an investigation would then be completed and a summary, either verbally or in-writing, would be provided to the complainant.	F0585		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. The following complaints were reviewed: H52839648C	20000		08/08/2025

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 (2562308); order issued at 1880. 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 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		
21880	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 20 Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well	21880	corrected.	08/14/2025

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21880	Continued from page 2 as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure voiced concerns about the provision of care were acted upon timely and resolved to help potentially prevent occurrences for 3 of 3 residents (R1, R4, R6) reviewed who had voiced concerns about care from a staff member. Findings include: A facility-reported Vulnerable Adult Maltreatment Report (i.e,, FRI) dated, 7/16/25, identified R1 reported being handled roughly by a nursing assistant (NA) the night prior. The report identified NA-A as the alleged perpetrator and outlined they had been terminated from the care center. The report continued and identified another resident (R6) had reported concerns about how NA-A had transferred them and, again, that NA-A was rough with cares. R1's admission Minimum Data Set (MDS), dated 6/19/25, identified R1 had moderate cognitive impairment but demonstrated no delusional thinking. On 7/24/25 at 11:27 a.m., R1 was interviewed and recalled the incident from the week prior. R1 expressed it involved a male staff member who she felt was rough when doing	21880		

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21880	Continued from page 3	21880		

cares. R1 stated she was sleeping at night and then suddenly, "Next thing I knew, I was against the wall." R1 stated the male staff member just rolled her over without waking her up which caused her to be startled and have some pain. R1 stated being moved by him without warning was upsetting adding aloud, "It was too hard [how he moved her]." R1 stated she reported this concern to someone at the care center but was unsure whom.

R1's Aeris History & Physical, dated 7/14/25, identified R1 was evaluated by the medical doctor (MD) who outlined, "Patient' neurostatus [sic] has not changed but she does claim there was some roughness with her last night ... claims that somebody beat her up at this time but it is vague ... gave to social service director [ ] and they are going to investigate. No reported injury noted last evening but she does have palpatory tenderness ... will do an x-ray at this time."

When interviewed on 7/24/25 at 12:13 p.m., NA-B stated they had worked at the campus through their agency for "approximately three or four months." NA-B stated they were aware R1 had reported "someone had rough handled her," and verified they had worked the shift with NA-A on the date of the alleged incident. NA-B stated they had never physically seen NA-A be intentionally abusive to any residents, however, had reported some concerns prior about his care to other staff members. NA-B stated "the resident's" had reported concerns that NA-A would "move too fast" with cares and, as a result, NA-B had told NA-A he needed to "slow down" while providing care. At 12:52 p.m., a follow-up interview was completed with NA-B. NA-B explained they had first heard residents' concerns being expressed about NA-A "as soon as I came here" and started working several months prior. NA-B reiterated the comments by the residents started at the same time and expressed they felt it was already being addressed from appearances. NA-B stated several residents had complained about NA-A and his provided care and named R4. NA-B stated residents' comments were often about NA-A moving "too fast" and explained there had also been one incident where a resident who used a mechanical lift was left suspended up while NA-A left the room to get incontinence products which NA-B attributed to a lack of organization with cares and a need for additional training. NA-B stated NA-A could be "not easy to talk to" and help improve his cares as he seemed to "take is sometimes personally." NA-B stated they felt the management was aware of these concerns, including from months' prior, as "the charge nurse" who often worked as aware of the concerns, too. NA-B stated multiple

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21880	Continued from page 4 nurses who had worked with NA-A also, "Say the same thing." NA-B reiterated the employee all of these concerns had been reported and/or observed with was NA-A. R4's quarterly Minimum Data Set (MDS), dated 6/8/25, identified R4 had moderate cognitive impairment but demonstrated no delusional thinking. On 7/24/25 at 2:20 p.m., R4 was interviewed about his services in the nursing home and responded aloud, "Not great." R4 was questioned if he had any concerns about the care provided by NA-A he could recall to which R4 responded aloud, "[NA-A] I had trouble with." R4 explained NA-A had never physically hurt him but rather just "comes on strong" and did not always explain cares or what he wanted adding, "It's a demand thing by him." R4 added, "I don't like that." R4 stated he had told the staff at the desk about these concerns but was dismissed with a "boys will be boys" response. R6 was discharged from the care center at the time of survey and unavailable for interview. During the abbreviated survey, a telephone interview was attempted with NA-A; however, they were unable to be reached. When interviewed on 7/24/25 at 1:43 p.m., licensed practical nurse (LPN)-A verified they routinely worked the overnight shift and had worked with NA-A. LPN-A stated they had never observed or had anyone report concerns about NA-A's care on the night shift prior adding, "He was one of the nicest guys there ever was." The facility-provided WVP (Waterview Pines) Grievances listing, dated 1/1/25 to 7/25/25, identified all filed grievances along with each' respective incident number, category, resident involved, date reported and resolution date. The listing identified R4 had filed a grievance in April 2025 related to call light response; however, the listing outlined no grievances were filed for R1, R4, R5 related to provision of care concerns. The provided listing lacked employee name details. During the abbreviated survey, no evidence was provided to demonstrate the facility' had acted upon the concerns expressed by residents to NA-B until 7/7/25 when a FRI for R4 was submitted; despite other staff hearing concerns from the residents about NA-A's provided care for several months prior. On 7/24/25 at 3:14 p.m., the administrator, director of nursing (DON), and social worker (SW)-A were interviewed, and SW-A verified they helped address and	21880		

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21880	Continued from page 5	21880		

Continued from page 5
manage grievances for the resident population. The administrator stated they were aware of "the two situations" which had a VA filed (i.e., R4, R1) about them and upon completing an investigation into those learned of R6 having concerns about NA-A's provided care. The administrator stated none of the staff had raised concerns about NA-A's care prior to those events adding, "Nobody has brought up any concerns." The administrator stated they had an "all staff" meeting recently, too, and nothing was voiced or raised about the NA's care. The administrator and DON both verified they were unaware of an incident involving a resident being left suspended in the air in a mechanical lift until now with the administrator adding, "This is news to me." The administrator and DON both expressed they would have immediately followed up on that concern if it had been reported to them. The management team all acknowledged they had not been told of the concerns as heard by the floor staff and were unaware of any concerns until 7/7/25, when the first FRI for R4 was submitted. The DON and administrator both acknowledged having completed no formal audits of NA-A's care including after 7/7/25, when the FRI was reported. The team all expressed a formal grievance would have likely been completed months prior if they had been told of the concerns with NA-A's care; and the administrator stated they would have acted upon it earlier (prior to 7/7/25) had the information reached them adding, "I absolutely would have [followed up]." The administrator stated no formal grievances were filed on the FRI(s) as they were reportable to the State agency; however, the administrator expressed it was important to ensure concerns were addressed and resolved timely "so it doesn't happen to the next person," adding further, "Little concerns can turn into something big if it's not addressed." Further, the administrator stated they felt having the new management at the care center and more frequent "all staff" meetings would help ensure concerns get reported more timely to them from the floor staff.

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21880	Continued from page 6 would be provided to the complainant. SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could review applicable policies and procedures to ensure reported concerns with care were forwarded to management to be acted upon; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days	21880		