

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered July 12, 2021

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

RE: CCN: 245471

Cycle Start Date: June 18, 2021

Dear Administrator:

On June 28, 2021, 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,

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 June 10, 2021

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

RE: CCN: 245471

Cycle Start Date: June 26, 2021

Dear Administrator:

On May 26, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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 Waterview Shores Llc June 10, 2021 Page 2

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" 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, 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 Waterview Shores Llc June 10, 2021 Page 3

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 August 26, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 26, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

The Waterview Shores Llc
June 10, 2021
Page 4
Food from to contact ma if you have a

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**

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

PRINTED: 06/21/2021 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	COM	IPLETED
		045.54	D W			С
NIANCE OF T	200//DED OF 01/201 :==	245471	B. WING_	OTDEET ADDRESS SITE OF STATE OF STATE	05/	26/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE		
THE WAT	TERVIEW SHORES LI	_C		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) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ΓS	F 00	00		
	abbreviated survey Your facility was for with the requiremen Requirements for L	ough 5/26/21, a standard was conducted at your facility. and to be NOT in compliance of 42 CFR 483, Subpart B, ong Term Care Facilities.				
	SUBSTANTIATED:	laint was found to be				
	The following comp UNSUBSTANTIATE H5471022C (MN73 H5471024C (MN71	045)				
	as your allegation on Departments accept enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required first page of the CMS-2567 ic submission of the POC will tion of compliance.				
F 689 SS=D	onsite revisit of you validate that substa regulations has bee Free of Accident Ha	azards/Supervision/Devices	F 68	89		6/18/21
	as free of accident					
	/ DIRECTOR'S OF PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATI IPE	TITLE		(X6) DATE
	ically Signed	LINGOFFEILIX INLFINEDENTATIVE 3 SIGI	VALUIVE	IIILE		06/16/2021
	, ,					•

(X2) MULTIPLE CONSTRUCTION

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.

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION ((X3) DATE SURVEY COMPLETED C	
		245471	B. WING		05/26/2021	
	PROVIDER OR SUPPLIER	_C		STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE TWO HARBORS, MN 55616	00/20/2021	
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 689	supervision and as accidents. This REQUIREMED by: Based on interview facility failed to ider to reduce the likelih develop a comprehidentified fall risk faresident centered in	ge 1 sistance devices to prevent NT is not met as evidenced and document review, the stify individualized risk factors good of falls, and failed to ensive care plan which ctors and/or implement enterventions to reduce the risk sidents (R2, R4) reviewed for	F 689	Immediate Corrective Action: Resident #2 and #3's care plans were reviewed and updated with a comprehensive care plan which identiall risk factors and resident centered interventions were implemented to rethe risk of falls.	atified d	
	R2's diagnoses inc and osteoporosis (I R2's admission Mir 4/16/21, indicated I impairment, impair	nimum Data Set (MDS) dated R2 had moderate cognitive ed vision, required extensive nsfers and ambulation, and no		Corrective Action as it applies to other The Policy and Procedure for Fall Prevention and Management were reviewed and remain current. All residents will be reviewed to ensu comprehensive assessment/care pla been completed for falls and approp resident centered interventions are in place.	ure a an has riate	
	4/16/21, indicated R related to anti-depr CAA indicated R2 R and was attending therapy (PT/OT) to CAA indicated R2 wrisk. R2's care plan updaindicated R2 was rimobility. The care p PT/OT orders, R2 was rimobility.	sessment (CAA) dated R2 was a high risk for falls essant use and vertigo. The lad one fall since admission, physical therapy/occupational improve her balance. The would be care planned for fall lated and received 5/26/21, sk for falls related to impaired plan directed the staff to follow was to always wear gripper and wearing her shoes, keep		All management nurses will be re-educated on the Fall Prevention a Management Policy and education winclude the need to complete a comprehensive assessment/care pland appropriate resident centered interventions after falls. Recurrence will be prevented by: Audits of 5 residents who have had will be assessed weekly x 4 then mox 2 to ensure that a comprehensive assessment/care plan was complete appropriate resident centered interventions were put into place after	vill an falls inthly ed and	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245471	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	LC		40	TREET ADDRESS, CITY, STATE, ZIP CODE 02 - 13TH AVENUE WO HARBORS, MN 55616	1 001	20,2021
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F 689	call-light within read safety. The care plainformation on past cause of falls, recorpotential causes if provided in the facility from 2/25/21, through falls on 4/18/21, and On 4/19/21, R2's producible fall. On 5/5/21, R2's producible fall. R2's producible fall. R2's medical record assessment following a gain provided. R2's family record assessment following interventions to preher falls on 4/18/21 R4's Admission Record falls on 4/18/21 R4's Admission Record falls on 4/18/21 R4's admission MD had severe cognitive extensive assistance	ch, monitor and document on an further directed to review a falls and attempt to determine rd root cause and remove any possible. Ity provided incident reports gh 5/24/21, indicated R2 had d 5/5/21. Ity gress note indicated the red R2's daughter related to a solve of the floor of the floo	F6	89	falls. The results of the audits will shared with the facility QAPI comm for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/Nurse Manager/Designee	nittee	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP C 402 - 13TH AVENUE TWO HARBORS, MN 55616		512012021	
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F 689	indicated R4 was history of falls, uns of safety awarene three falls since at R4's Care Plan inirisk for falls, with a falls. The care plachecks, move R4 administer schedublanket for her lap socks at night, kerclutter, floor mat mithin reach. Review of the faci from 2/25/21, throfalls on 4/1/21, 4/24/12/21, 4/15/21, and 5/23/indication of monit post fall vital signs. On 5/24/21, at 10: indicated R4 per ficheck on R4 more due to impulsive norder was obtaine and concerns R4 entirely which can to go to the bathrofindicated R4 had management, and random times sinc complaints of pair	essessment (CAA) dated 4/7/21, at high risk for falls related to steadiness, weakness, and lack ss. The CAA indicated R4 had	F 6	89			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 689	time. If R4 does no consideration for H R4 may be having with rounding MD in consideration in lig continues agitation interventions. On 5/25/21, at 3:12 director of nursing documentation of F lacked a comprehencause analysis and for R2's falls. The E been. The DON als repeated falls from DON stated the factomprehensive assand review/add inteat the time of the in was not until 5/24/2 interventions, a corroot cause analysis recent fall on 5/23/2. The facility policy F Management revise the protocol is to id implement fall previous guidelines for asse to assist staff in ide policy directed that Fall Risk Evaluation residents risk factor initial interventions, or different interver current approach refurther directed sta	ot respond to interventions, lospice may be appropriate as terminal agitation. Will discuss in the morning for further that of frequent falls at home and with falls despite multiple 2 p.m. during interview, the (DON) confirmed the R2's fall on 4/18/21, and 5/5/21, ensive assessment, and root a follow up were not completed DON stated they should have so verified R4 had multiple 4/1/21, through 5/23/21. The cility failed to complete sessments, root cause analysis erventions to address the falls incidents. The DON stated it 21, that additional imprehensive assessment and is were completed for R4's most 21.	F 68				

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

245471 B. WING	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW SHORES LLC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 5 24 hours post fall and monitor and document resident's response and effectiveness of			245471	B. WING _			l		
F 689 Continued From page 5 24 hours post fall and monitor and document resident's response and effectiveness of			L		402 - 13TH AVENUE	CODE	1 001	20/2021	
24 hours post fall and monitor and document resident's response and effectiveness of	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD E APPROPF	BE	COMPLETION	
	F 689	24 hours post fall a resident's response	nd monitor and document and effectiveness of	F 68	39				



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 10, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: 9J1Z11

Dear Administrator:

The above facility was surveyed on May 24, 2021 through May 26, 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 June 10, 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

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00844	B. WING		05/2/	
		00844			05/20	6/2021
NAME OF	PROVIDER OR SUPPLIER			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
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall with a schedule of the Minnesota Department of White Programme 1997 with a schedule of the Minnesota Department of White Programme 1997 with a schedule of the Minnesota Department of White Programme 1997 with a schedule of the Minnesota Department of White Programme 1997 with a schedule of the Minnesota Department of the Programme 1997 with a schedule of the Minnesota Department of the Programme 1997 with a schedule of the Minnesota Department of the Programme 1997 with a schedule of the Minnesota Department of the Min	nether a violation has been				
	number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	rule provided at the tag le number indicated below. In several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	was conducted at y the Minnesota Depa facility was found N State Licensure. Pla plan of correction ye	rs: n 5/26/21, a complaint survey our facility by surveyors from artment of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders e when they will be completed.	:			

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

Electronically Signed 06/16/21

STATE FORM 6899 If continuation sheet 1 of 8 9J1Z11

TITLE

(X6) DATE

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00844	B. WING		05/2	26/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		402 - 13T	H AVENUE			
THE WA	TERVIEW SHORES LL	-C TWO HAF	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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED: H5471023C (MN72 issued at 0830.	laint was found to be 794) with a licensing order				
	UNSUBSTANTIATE H5471022C (MN73 H5471024C (MN71	045)				
	the State Licensing Federal software. T assigned to Minnes Nursing Homes. Th appears in the far-le Tag." The state sta	nent of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for e assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies"				
	the correction order the findings which a statute after the sta as evidence by." Fo are the Suggested	es the "To Comply" portion of T. This column also includes are in violation of the state tement, "This Rule is not met illowing the surveyor's findings Method of Correction and				
	receipt of State lice the Minnesota Depa Informational Bullet	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at				
	n/infobulletins/ib14_ orders are delineate Department of Heal you electronically.	state.mn.us/facilities/regulatio _1.html The State licensing ed on the attached Minnesota Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please				
	enter the word "CO available for text. You electronic State lice	RRECTED" in the box ou must then indicate in the ensure process, under the date, the date your orders will				

Minnesota Department of Health

STATE FORM 9J1Z11 If continuation sheet 2 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
			, 20.25			;
		00844	B. WING		05/2	6/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE WAT	TERVIEW SHORES LI	LC 402 - 13TH 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 APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	the Minnesota Depais enrolled in ePOC not required at the state form. PLEASE DISREGATOURTH COLUMN "PROVIDER'S PLAAPPLIES TO FEDE THIS WILL APPEA	o electronically submitting to artment of Health. The facility and therefore a signature is bottom of the first page of ARD THE HEADING OF THE WHICH STATES, IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.	2 000			6/18/21
2 030	Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 630			0/10/21
	by: Based on interview facility failed to ider to reduce the likelih develop a compreh identified fall risk fa resident centered in	and document review, the ntify individualized risk factors good of falls, and failed to ensive care plan which ctors and/or implement interventions to reduce the risk sidents (R2, R4) reviewed for		Immediate Corrective Action: Resident #2 and #3's care plans we reviewed and updated with a comprehensive care plan which id fall risk factors and resident center interventions were implemented to	entified ed	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	
AND I LAN	O. COMMEDITION	IDENTIFICATION NOISIDEN.	A. BUILDING:	·	CONTR	,
					c	
		00844	B. WING		05/2	6/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS CITY S	STATE, ZIP CODE		
10.000	TOVIDEIX OIX GOTT EIEIX	402 - 13Th		517 (12, 2.11 °COBL		
THE WAT	TERVIEW SHORES LI	C:	BORS, MN	55616		
()(A) ID	CLIMMAN DV CTA	TEMENT OF DEFICIENCIES	-	PROVIDER'S PLAN OF CORRECTION)NI	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 3	2 830			
	accidents.			the risk of falls.		
	Findings included:			Corrective Action as it applies to o	thers:	
	R2's Admission Record printed 5/26/21, indicated			The Policy and Procedure for Fall		
	R2's diagnoses included visual loss of left eye and osteoporosis (bone weakness).			Prevention and Management were reviewed and remain current.		
	, ,	,		All regidents will be reviewed to on	ouro o	
		imum Data Set (MDS) dated R2 had moderate cognitive		All residents will be reviewed to ensure a comprehensive assessment/care plan has		
		ed vision, required extensive		been completed for falls and appro		
		nsfers and ambulation, and no		resident centered interventions are		
	history of falls prior	to admission.		place.		
	R2's Care Area Ass	essment (CAA) dated		All management nurses will be		
		R2 was a high risk for falls		re-educated on the Fall Prevention	n and	
		essant use and vertigo. The		Management Policy and education	n will	
		ad one fall since admission,		include the need to complete a		
		ohysical therapy/occupational		comprehensive assessment/care	plan and	
		improve her balance. The		appropriate resident centered		
		ould be care planned for fall		interventions after falls.		
	risk.			Recurrence will be prevented by: Audits of 5 residents who have had	d falle	
	R2's care plan unda	ated and received 5/26/21,		will be assessed weekly x 4 then r		
		sk for falls related to impaired		x 2 to ensure that a comprehensiv	-	
		olan directed the staff to follow		assessment/care plan was comple		
		vas to always wear gripper		appropriate resident centered		
		and wearing her shoes, keep		interventions were put into place a	fter	
	call-light within read	ch, monitor and document on		falls. The results of the audits will		
		an further directed to review		shared with the facility QAPI comn		
		falls and attempt to determine		input on the need to increase, dec	rease or	
	cause of falls, recor	rd root cause and remove any		discontinue the audits.		
	potential causes II [วบออเมเษ.		Corrections will be monitored by:		
	Review of the facilit	y provided incident reports		Seriodions will be morniored by.		
		gh 5/24/21, indicated R2 had		DON/Nurse Manager/Designee		
	falls on 4/18/21, and					
	On 4/40/24 Date	rogrand note indicated the				
		ogress note indicated the ed R2's daughter related to a				

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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			C 26/2021
	PROVIDER OR SUPPLIER TERVIEW SHORES LI	C 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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	fall. On 5/5/21, R2's protransferring back to nursing assistant (Nososhe was gently lesigns were stable a gripper socks were not gripping well duwas not using a gai provided. R2's familian R2's medical record assessment following interventions to preher falls on 4/18/21 R4's Admission Rec R4's diagnoses included back pain, kyphosis causing excessive and osteoporosis (king R4's admission MD had severe cognitive extensive assistance ambulation, and halp admission. R4's Care Area Assindicated R4 was an history of falls, unstof safety awareness three falls since admission. R4's Care Plan initiatisk for falls, with a falls. The care plan checks, move R4 to nurse falls. The care plan checks, move R4 to nurse falls. The care plan checks, move R4 to nurse falls.	egress note indicated she was bed with assistance from a NA) and her feet were slipping owered to the floor. R2's vital nd she had no injury. New applied as her old ones were e effects of washing. The NA to belt, and staff education was ly was updated. If lacked a comprehensive ng the fall, and lacked vent subsequent falls following, and 5/5/21. Cord printed 5/26/21, indicated udded reduced mobility, lower a (abnormality of the spine curvature of the upper back) cone weakness). If dated 4/7/21, indicated R4 impairment, required the with transfers and do history of falls prior to the sessment (CAA) dated 4/7/21, thigh risk for falls related to eadiness, weakness, and lack is. The CAA indicated R4 had	2 830			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			,
		00844	B. WING			.6/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE WAT	ERVIEW 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
	socks at night, keer clutter, floor mat new within reach. Review of the facility from 2/25/21, through falls on 4/1/21, 4/2/4/12/21, 4/15/21, 4/5/17/21, and 5/23/2 indication of monitor post fall vital signs, On 5/24/21, at 10:0 indicated R4 per face check on R4 more due to impulsiveness order was obtained and concerns R4 mentirely which can be to go to the bathroof indicated R4 had management, and random times since complaints of pain cognitive impairment time. If R4 does no consideration for HR4 may be having the with rounding MD in consideration in light continues agitation interventions. On 5/25/21, at 3:12 director of nursing (documentation of Flacked a compreher)	ge 5 when restless, wear gripper or room clean and free of ext to bed, and keep call-light by provided incident reports gh 5/24/21, indicated R4 had 21, 4/3/21, 4/5/21, 4/10/21, 1/17/21, 4/18/21, 5/3/21, 5/8/21, 1/1. R4's medical record lacked oring R2 post fall, completing and fall interventions. 5 p.m. a progress note ll on 5/23/21, staff instructed to frequently if napping in room ess. The note also indicated an due to review of mediations and not be evacuating bowels contribute to feeling of having om and restlessness. The note redications in place for pain upon frequent interviews at a admission R4 has no overall. R4 had significant and was very restless at this trespond to interventions, cospice may be appropriate as the morning for further at of frequent falls at home and with falls despite multiple 1. p.m. during interview, the (DON) confirmed the expectation of th	2 830			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED				
		00844	B. WING		l l	C 26/2021				
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW SHORES LLC STREET ADDRESS, CITY, STATE, ZIP CODE 402 - 13TH AVENUE TWO HARBORS, MN 55616										
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION				(X5) COMPLETE DATE					
2 830	been. The DON als repeated falls from DON stated the fac comprehensive ass and review/add interest at the time of the in was not until 5/24/2 interventions, a con root cause analysis recent fall on 5/23/2. The facility policy F Management revise the protocol is to idimplement fall previguidelines for asset to assist staff in ide policy directed that Fall Risk Evaluation residents risk factor initial interventions, or different intervent current approach refurther directed staff define details of the 24 hours post fall a	o verified R4 had multiple 4/1/21, through 5/23/21. The ility failed to complete sessments, root cause analysis erventions to address the falls cidents. The DON stated it it, that additional apprehensive assessment and were completed for R4's most 21. all Prevention and ed 2/21, defined the purpose of entify residents at risk for falls, ention interventions, provide asing a resident after a fall and ntifying causes of the fall. The nursing staff are to complete a into identify and document are. If falling recurs despite staff will implement additional attions, or indicate why the emains relevant. The policy of identify causes of a fall, it is and effectiveness of	2 830							
	The Director of Nur develop, review, an procedures to ensu analysis are comples subsequent falls as comprehensive car factors and/or imples interventions. The DON or design	HOD OF CORRECTION: sing (DON) or designee could d/or revise policies and re comprehensive root cause eted to reduce the likelihood of well as develop a e plan which identifies fall risk ement resident centered the could educate all the policies and procedures								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED							
		IDENTIFICATION NUMBER:	A. BUILDING:									
00844			B. WING		05/26/2021							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
THE WATERVIEW SHORES LLC 402 - 13TH AVENUE TWO HARBORS, MN 55616												
(X4) ID PREFIX TAG	(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE								
2 830	Continued From pa	ige 7	2 830									
		nee could develop monitoring ongoing compliance.										
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one										

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