Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 7, 2025

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

RE: CCN: 245471
Cycle Start Date: November 6, 2024

Dear Administrator:

On December 13, 2024, 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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Electronically delivered

January 7, 2025

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

Re: Reinspection Results
Event ID: REP612

Dear Administrator:

On December 13, 2024 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 November 6, 2024. 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
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Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 19, 2024

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

RE: CCN: 245471
Cycle Start Date: November 6, 2024

Dear Administrator:

On November 6, 2024, a survey was completed at your facility by the Minnesota Department 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 February 6, 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 by May 6, 2025 (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
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245471	A. BUILDING ______ B. WING ______	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 11/5/24 through 11/6/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed.: H54711007C (MN00107883) with a deficiency issued at F550. In addition as a result of the investigation, a deficiency was cited at F656. 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.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each	F 550		12/2/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/27/2024

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

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F 550	Continued From page 1 resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were assisted with activities of daily living (ADLs) in a dignified manner for 2 of 2 residents (R2, R3) reviewed. Findings include:	F 550	Immediate Corrective Action: R2’s facial hair was shaved, and care plan was updated to direct staff to offer assistance in removing facial hair and respect resident’s right to refuse this service. Staff responsible educated on providing feeding assistance while sitting next to resident	

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F 550	Continued From page 2 R2 R2's admission Minimal Data Set (MDS) dated 10/10/24, indicated R2 had diagnoses of cerebral infarction (stroke) and anxiety disorder. R2's care plan dated 10/4/24, indicated R2 had a self-care care deficit related to ischemic stroke and required staff assistance with personal hygiene. R2's care plan was revised 11/6/24 (after survey entrance), indicated R2 would often refuse to have facial hair removed when offered, this had been a long-standing preference from before admission to the facility. Further R2's care plan revised on 11/6/24, directed staff to offer assistance in removing facial hair and respect resident's right to refuse this service. R2's care plan lacked evidence of shaving preference prior to the start of survey. R3 R3's annual MDS dated 10/30/24, indicated R3 had diagnoses of traumatic brain injury (TBI), mood disorder, and dysphagia (difficulty swallowing). R3's care plan last reviewed on 8/12/24, indicated R3 required staff to assist with eating as needed due to vision. During an observation on 11/5/24 at 12:10 p.m., R3 was observed sitting in a standard wheelchair at a table in the commons area by the nursing station. NA-A was standing to the left of R3, and NA-A was noted to have her left hand on her left hip while physically feeding R3 with her right hand. NA-A was visiting with R3 while assisting	F 550	rather than standing and observed providing feeding assistance during next meal time. Corrective Action as it applies to others: Activities of Daily Living Policy reviewed and remains current. The nursing department educated on offering assistance in ADL's as well as documenting refusals for all residents. The nursing department educated on offering assistance in feeding and sitting next to residents while feeding them instead of standing. Reviewed other residents who require grooming assistance to ensure they are receiving grooming assistance timely and necessarily. Reviewed other residents who require feeding assistance and observed staff providing feeding assistance to them during mealtimes to ensure that staff are sitting next to residents and not standing. Date of compliance: 12/2/2024 Recurrence will be prevented by: Audits of 3 other residents ADL assistance will be completed weekly x4 weeks, and then monthly x2 months to ensure that resident received assistance in removing facial hair per the care plan. Audits of 3 residents needing feeding assistance will be completed weekly x4 weeks, and then monthly x2 months to ensure staff are sitting with the residents and not standing next to them. 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: DON or	

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F 550	Continued From page 3	F 550		

her with eating. At 12:18 p.m., NA-A continued to stand over R3 and assisted R3 with noon meal.

During an observation on 11/5/24 at 12:27 p.m., R2 was observed self-propelling down the hallway in her standard wheelchair towards her room. R2 was noted to have many visible white/gray whiskers on her chin.

During an observation and interview on 11/5/24 at 12:37 p.m., R2 was laying in her bed and appeared comfortable. R2 stated staff assist her with bathing, dressing, toileting, and hygiene. When asked if staff assist R2 with shaving, R2 placed her right hand up to her chin and stated, "I like to be shaved, I don't like whiskers". R2 stated staff did not offer to help her shave today. R2 was noted to have multiple long white and gray whiskers on her chin that would be visible to other people.

During an interview on 11/5/24 at 1:46 p.m., NA-A stated she had worked with R2 in her previous living situation and stated R2 would allow staff to assist with ADLs. NA-A stated R2 required staff assistance with toileting, transferring, dressing, and hygiene. Further, NA-A stated staff were expected to assist each resident with shaving, however R2 "doesn't want me to touch her face". NA-A stated R3 required staff assistance with eating due to R3 being unable to hold onto the utensils. NA-A stated when assisting a resident with a meal, NA-A did not sit due to multitasking with other things.

During an interview on 11/5/24 at 4:21 p.m., NA-B stated staff were expected to ask each resident and assist with shaving if staff noticed any whiskers and each resident had their own razor.

Plan of correction (F 550, continued): Designee.

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F 550	Continued From page 4	F 550		

NA-B was not familiar with R2 and did not assist her often. Further, NA-B stated R3 required staff assistance with eating. NA-B stated staff attempted to sit with the resident when they were assisting with their meal.

During an interview on 11/5/24 at 6:34 p.m., NA-C stated staff were expected to ask and offer each resident assistance with shaving and each resident has their own razor. Further, NA-C stated if a resident were to refuse, staff were expected to report to the nurse and chart the refusal in the resident's record.

During an interview on 11/6/24 at 8:18 a.m., licensed practical nurse (LPN)-A stated R2 did not have a history of refusing cares or staff assistance however, LPN-A stated she was informed by a NA that R2 did not want to be shaved. LPN-A confirmed she observed R2's whiskers and did not offer to assist R2 because she did not want to make R2 feel bad. LPN-A stated staff were expected to offer a resident assistance with shaving when they observed it was needed or on shower days. Further, LPN-A stated R3 required staff assistance with eating, and staff were expected to sit next to R3 while assisting her and not "towering over her", and staff should be having conversation with R3 during the meal.

During an interview on 11/6/24 at 8:53 a.m., interim director of nursing (DON) stated staff were expected to re-approach or provide education to a resident if the resident were to refuse any cares, as well as chart in the resident's behavior tracking on refusals. DON stated if a resident were to have a history of refusals, the resident's care plan would be updated to reflect

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F 550	Continued From page 5	F 550		

the history of refusals and interventions in place for staff to implement. Further, DON stated she was not very familiar with R2 however, confirmed R2's medical record did not have any documentation of R2 refusing assistance with shaving and R2's care plan lacked evidence of R2's shaving preferences. Further, DON stated staff were expected to be seated next to the resident at their level and having a conversation with the resident while assisting them with their meal. DON stated sitting at the resident's level was less intimidating to the resident.

During an observation and interview on 11/6/24 at 11:20 a.m., R2 was observed in her room laying in bed while reading the newspaper, and there were no visible whiskers on her chin. R2 stated staff just assisted her with shaving and she felt "much better".

During an interview on 11/6/24 at 11:23 a.m. LPN-A confirmed she had asked R2 if she would like to be shaved and R2 "actually wanted it done". LPN-A stated she had asked R2 about shaving and R2 stated she would like to be shaved every two- three days.

Review of facility policy titled Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, indicated the intent of the policy was to create and sustain an environment that humanized and individualized each resident's quality of life by ensuring all staff understand the principles of quality of life, and care and services provided are person-centered, and honor and support each resident's preferences, choices, values, and beliefs. Further, policy indicated facility would provide care and services for the following ADLS: hygiene-grooming, and

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F 550	Continued From page 6 dining-eating.	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		12/2/24

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F 656 Continued From page 7
local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure resident's care plan was implemented appropriately during transfers for 1 of 2 residents (R2) reviewed.

Findings include:

R2's admission Minimal Data Set (MDS) dated 10/10/24, indicated R2 had diagnoses of cerebral infarction (stroke) and anxiety disorder.

R2's care plan dated 10/4/24, indicated R2 had an alteration in mobility related to ischemic stroke and directed staff to follow physical therapy instructions, and assist R2 with ambulation and transfers. R2 required assist of one staff, with front wheeled walker (FWW), and a gait belt. Further, R2 was identified to be at risk for falls related to ischemic stroke and psychotropic medication use and directed staff to follow physical therapy and occupational therapy instructions for mobility function.

Facility document untitled and undated, however floor staff referred to the document as the "care guide sheet", indicated R3 required assist of one staff for transfers and staff to follow behind R3

F 656

Immediate Corrective Action: CNA responsible re-educated on following care guides involving transfer and reminded to utilize a gait belt if necessary.
Corrective Action as it applies to others:
Care Planning Policy reviewed and updated.
Nurse management educated on updating care guides and care plan for residents.
Nursing department educated on ensuring they are following care plans and care guides when caring for all residents.
Audit of all care guides completed to ensure care guide matches care plan for R2 and all other residents.
Date of compliance: 12/2/2024
Recurrence will be prevented by: Audits of resident transfers and the coinciding care guide for 3 residents will be completed weekly x4 weeks, and then monthly x2 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: DON or Designee.

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F 656

Continued From page 8

with wheelchair while ambulating. The document lacked evidence of R3 requiring the use of a gait belt for transfers.

During an observation on 11/5/24 at 12:29 p.m., nursing assistant (NA)-A was observed to assist R2 with transferring from her wheelchair to the toilet. NA-A assisted R2 into the bathroom and directed R2 to grab the handrail and stand up from her wheelchair. R2 stood up and pivoted from wheelchair and sat onto toilet. NA-A then directed R2 to again grab the handrail and stand up from the toilet to perform toileting hygiene cares and NA-A assisted R2 with pulling up her incontinent brief and pants, and R2 pivoted and sat back down in her wheelchair. NA-A did not utilize a gait belt for either transfer. Further, NA-A assisted R2 in her wheelchair out of the bathroom and next to the bed and directed R2 to grab the handrail on the bed to stand up. When questioned about utilizing a gait belt at that time, NA-A stated, "she won't wait, probably should use a gait belt, I don't know" and continued to transfer R2. R2 pivoted and sat on the edge of her bed and NA-A assisted R2 to lay down in bed and then exited R2's room.

During an interview on 11/5/24 at 1:46 p.m., NA-A stated R2 thought she was more independent than she was and had a history of falls in previous living setting. NA-A stated R2 would often self-transfer to the bathroom without notifying staff. Further, NA-A stated R2 required assist of one staff and she was a stand pivot transfer. NA-A stated R2 required staff to utilize a gait belt for transfers however, R2 did not have a gait belt available in her room or a pouch on her wheelchair for staff to utilize. In addition, NA-A stated staff were expected to utilize the care

F 656

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245471	A. BUILDING ______ B. WING ______	C 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656		F 656		

Continued From page 9
guide sheets or the resident's care plan accessible on staff's tablet at the nursing station to reference each resident's transfer status.

During an interview on 11/5/24 at 4:21 p.m., NA-B stated she was not familiar with R2's care needs however, staff were expected to refer to the care guide sheet that was at the nursing station. The care sheet was a printout staff were expected to keep in their pockets however, NA-B did not have one in her pocket.

During an interview on 11/5/24 at 6:34 p.m., NA-C stated R2 required limited assistance with transfers and did not require the use of a gait belt. NA-C stated staff were expected to utilize the care guide sheets as a reference on what each resident's care needs were including transfer status.

During an interview on 11/6/24 at 8:18 a.m. licensed practical nurse (LPN)-A stated R2 required assist of one staff contact guard assist with ambulation and transfers with her walker. LPN-A stated staff utilized a gait belt if one was ordered however, R2 did not require a gait belt.

During an interview on 11/6/24 at 8:53 a.m., interim director of nursing (DON) stated she was not familiar with R2's care and referred to the care plan which identified R2 required assist of one with a gait belt for transfers. Further, DON stated each resident who required a gait belt would have their own kept either in their room or in a pouch on their wheelchair.

During an interview on 11/6/24 at 9:33 a.m., director of therapy stated R2 was a pivot transfer with her four wheeled walker (4WW) and staff

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

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F 656	Continued From page 10 should be utilizing a gait belt during the transfers for safety. Review of facility policy titled Care Planning revised 1/6/22, indicated the care plan should be used in developing the resident's daily care routines and would be utilized by staff personnel for the purposes of providing care or services to the resident.	F 656		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 19, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: REP611

Dear Administrator:

The above facility was surveyed on November 5, 2024 through November 6, 2024 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW SHORES LLC	**402 - 13TH AVENUE TWO HARBORS, MN 55616**

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2 000	Initial Comments	2 000		

*****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 11/5/24 through 11/6/24, 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 order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed

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2 000	Continued From page 1	2 000		

these orders and identify the date when they will be completed.

The following complaint was reviewed: H54711007C (MN00107883) with a licensing order issued at 1805.

In addition as a result of the investigation, a licensing order was cited at 0565.

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

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2 000	Continued From page 2 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident's care plan was implemented appropriately during transfers for 1 of 2 residents (R2) reviewed. Findings include: R2's admission Minimal Data Set (MDS) dated 10/10/24, indicated R2 had diagnoses of cerebral infarction (stroke) and anxiety disorder. R2's care plan dated 10/4/24, indicated R2 had an alteration in mobility related to ischemic stroke and directed staff to follow physical therapy	2 565	Corrected	12/2/24

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2 565	Continued From page 3 instructions, and assist R2 with ambulation and transfers. R2 required assist of one staff, with front wheeled walker (FWW), and a gait belt. Further, R2 was identified to be at risk for falls related to ischemic stroke and psychotropic medication use and directed staff to follow physical therapy and occupational therapy instructions for mobility function. Facility document untitled and undated, however floor staff referred to the document as the "care guide sheet", indicated R3 required assist of one staff for transfers and staff to follow behind R3 with wheelchair while ambulating. The document lacked evidence of R3 requiring the use of a gait belt for transfers. During an observation on 11/5/24 at 12:29 p.m., nursing assistant (NA)-A was observed to assist R2 with transferring from her wheelchair to the toilet. NA-A assisted R2 into the bathroom and directed R2 to grab the handrail and stand up from her wheelchair. R2 stood up and pivoted from wheelchair and sat onto toilet. NA-A then directed R2 to again grab the handrail and stand up from the toilet to perform toileting hygiene cares and NA-A assisted R2 with pulling up her incontinent brief and pants, and R2 pivoted and sat back down in her wheelchair. NA-A did not utilize a gait belt for either transfer. Further, NA-A assisted R2 in her wheelchair out of the bathroom and next to the bed and directed R2 to grab the handrail on the bed to stand up. When questioned about utilizing a gait belt at that time, NA-A stated, "she won't wait, probably should use a gait belt, I don't know" and continued to transfer R2. R2 pivoted and sat on the edge of her bed and NA-A assisted R2 to lay down in bed and then exited R2's room.	2 565		

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2 565	Continued From page 4	2 565		

During an interview on 11/5/24 at 1:46 p.m., NA-A stated R2 thought she was more independent than she was and had a history of falls in previous living setting. NA-A stated R2 would often self-transfer to the bathroom without notifying staff. Further, NA-A stated R2 required assist of one staff and she was a stand pivot transfer. NA-A stated R2 required staff to utilize a gait belt for transfers however, R2 did not have a gait belt available in her room or a pouch on her wheelchair for staff to utilize. In addition, NA-A stated staff were expected to utilize the care guide sheets or the resident's care plan accessible on staff's tablet at the nursing station to reference each resident's transfer status.

During an interview on 11/5/24 at 4:21 p.m., NA-B stated she was not familiar with R2's care needs however, staff were expected to refer to the care guide sheet that was at the nursing station. The care sheet was a printout staff were expected to keep in their pockets however, NA-B did not have one in her pocket.

During an interview on 11/5/24 at 6:34 p.m., NA-C stated R2 required limited assistance with transfers and did not require the use of a gait belt. NA-C stated staff were expected to utilize the care guide sheets as a reference on what each resident's care needs were including transfer status.

During an interview on 11/6/24 at 8:18 a.m. licensed practical nurse (LPN)-A stated R2 required assist of one staff contact guard assist with ambulation and transfers with her walker. LPN-A stated staff utilized a gait belt if one was ordered however, R2 did not require a gait belt.

During an interview on 11/6/24 at 8:53 a.m.,

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2 565	Continued From page 5 interim director of nursing (DON) stated she was not familiar with R2's care and referred to the care plan which identified R2 required assist of one with a gait belt for transfers. Further, DON stated each resident who required a gait belt would have their own kept either in their room or in a pouch on their wheelchair. During an interview on 11/6/24 at 9:33 a.m., director of therapy stated R2 was a pivot transfer with her four wheeled walker (4WW) and staff should be utilizing a gait belt during the transfers for safety. Review of facility policy titled Care Planning revised 1/6/22, indicated the care plan should be used in developing the resident's daily care routines and would be utilized by staff personnel for the purposes of providing care or services to the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with	21805		12/2/24

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21805	Continued From page 6 courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were assisted with activities of daily living (ADLs) in a dignified manner for 2 of 2 residents (R2, R3) reviewed. Findings include: R2 R2's admission Minimal Data Set (MDS) dated 10/10/24, indicated R2 had diagnoses of cerebral infarction (stroke) and anxiety disorder. R2's care plan dated 10/4/24, indicated R2 had a self-care care deficit related to ischemic stroke and required staff assistance with personal hygiene. R2's care plan was revised 11/6/24 (after survey entrance), indicated R2 would often refuse to have facial hair removed when offered, this had been a long-standing preference from before admission to the facility. Further R2's care plan revised on 11/6/24, directed staff to offer assistance in removing facial hair and respect resident's right to refuse this service. R2's care plan lacked evidence of shaving preference prior to the start of survey. R3 R3's annual MDS dated 10/30/24, indicated R3 had diagnoses of traumatic brain injury (TBI), mood disorder, and dysphagia (difficulty	21805	Corrected	

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21805	Continued From page 7	21805		

swallowing).

R3's care plan last reviewed on 8/12/24, indicated R3 required staff to assist with eating as needed due to vision.

During an observation on 11/5/24 at 12:10 p.m., R3 was observed sitting in a standard wheelchair at a table in the commons area by the nursing station. NA-A was standing to the left of R3, and NA-A was noted to have her left hand on her left hip while physically feeding R3 with her right hand. NA-A was visiting with R3 while assisting her with eating. At 12:18 p.m., NA-A continued to stand over R3 and assisted R3 with noon meal.

During an observation on 11/5/24 at 12:27 p.m., R2 was observed self-propelling down the hallway in her standard wheelchair towards her room. R2 was noted to have many visible white/gray whiskers on her chin.

During an observation and interview on 11/5/24 at 12:37 p.m., R2 was laying in her bed and appeared comfortable. R2 stated staff assist her with bathing, dressing, toileting, and hygiene. When asked if staff assist R2 with shaving, R2 placed her right hand up to her chin and stated, "I like to be shaved, I don't like whiskers". R2 stated staff did not offer to help her shave today. R2 was noted to have multiple long white and gray whiskers on her chin that would be visible to other people.

During an interview on 11/5/24 at 1:46 p.m., NA-A stated she had worked with R2 in her previous living situation and stated R2 would allow staff to assist with ADLs. NA-A stated R2 required staff assistance with toileting, transferring, dressing, and hygiene. Further, NA-A stated staff were

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21805	Continued From page 8	21805		

expected to assist each resident with shaving, however R2 "doesn't want me to touch her face". NA-A stated R3 required staff assistance with eating due to R3 being unable to hold onto the utensils. NA-A stated when assisting a resident with a meal, NA-A did not sit due to multitasking with other things.

During an interview on 11/5/24 at 4:21 p.m., NA-B stated staff were expected to ask each resident and assist with shaving if staff noticed any whiskers and each resident had their own razor. NA-B was not familiar with R2 and did not assist her often. Further, NA-B stated R3 required staff assistance with eating. NA-B stated staff attempted to sit with the resident when they were assisting with their meal.

During an interview on 11/5/24 at 6:34 p.m., NA-C stated staff were expected to ask and offer each resident assistance with shaving and each resident has their own razor. Further, NA-C stated if a resident were to refuse, staff were expected to report to the nurse and chart the refusal in the resident's record.

During an interview on 11/6/24 at 8:18 a.m., licensed practical nurse (LPN)-A stated R2 did not have a history of refusing cares or staff assistance however, LPN-A stated she was informed by a NA that R2 did not want to be shaved. LPN-A confirmed she observed R2's whiskers and did not offer to assist R2 because she did not want to make R2 feel bad. LPN-A stated staff were expected to offer a resident assistance with shaving when they observed it was needed or on shower days. Further, LPN-A stated R3 required staff assistance with eating, and staff were expected to sit next to R3 while assisting her and not "towering over her", and

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 9	21805		

Continued From page 9

staff should be having conversation with R3 during the meal.

During an interview on 11/6/24 at 8:53 a.m., interim director of nursing (DON) stated staff were expected to re-approach or provide education to a resident if the resident were to refuse any cares, as well as chart in the resident's behavior tracking on refusals. DON stated if a resident were to have a history of refusals, the resident's care plan would be updated to reflect the history of refusals and interventions in place for staff to implement. Further, DON stated she was not very familiar with R2 however, confirmed R2's medical record did not have any documentation of R2 refusing assistance with shaving and R2's care plan lacked evidence of R2's shaving preferences. Further, DON stated staff were expected to be seated next to the resident at their level and having a conversation with the resident while assisting them with their meal. DON stated sitting at the resident's level was less intimidating to the resident.

During an observation and interview on 11/6/24 at 11:20 a.m., R2 was observed in her room laying in bed while reading the newspaper, and there were no visible whiskers on her chin. R2 stated staff just assisted her with shaving and she felt "much better".

During an interview on 11/6/24 at 11:23 a.m. LPN-A confirmed she had asked R2 if she would like to be shaved and R2 "actually wanted it done". LPN-A stated she had asked R2 about shaving and R2 stated she would like to be shaved every two- three days.

Review of facility policy titled Activities of Daily Living (ADLs)/Maintain Abilities Policy dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00844	A. BUILDING: ______ B. WING ______	C 11/06/2024

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21805	Continued From page 10 3/31/23, indicated the intent of the policy was to create and sustain an environment that humanized and individualized each resident's quality of life by ensuring all staff understand the principles of quality of life, and care and services provided are person-centered, and honor and support each resident's preferences, choices, values, and beliefs. Further, policy indicated facility would provide care and services for the following ADLS: hygiene-grooming, and dining-eating. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		