Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 2, 2025

Administrator
The Waterview Shores LLC

402 - 13TH AVENUE
TWO HARBORS, MN 55616

RE: CCN: 245471
Cycle Start Date: 08/22/2025

Dear Administrator:

On September 11, 2025, 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 actual harm that was not immediate jeopardy (Level G),

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey; past non-compliance does not require a plan of correction (POC).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

- **Civil money penalty, (42 CFR 488.430 through 488.444).**

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/ Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 11, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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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Administrator
The Waterview Shores LLC
402 - 13TH AVENUE
TWO HARBORS, MN 55616

Re: Event ID: 1D649C-H1

Dear Administrator:

The above facility survey was completed on 09/11/2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245471	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterview Shores LLC	402 - 13TH AVENUE , TWO HARBORS, Minnesota, 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
F0000	INITIAL COMMENTS On 9/10/25 through 9/11/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed during the survey. H54713262C (2604181) with a deficiency issued at F656 HARM, PAST NON-COMPLIANCE. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		08/29/2025
F0656 SS = G	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).	F0656	"Past Noncompliance - no plan of correction required"	08/29/2025

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

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

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F0656 SS = G	Continued from page 1 (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 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 person centered fall interventions were care planned and implemented for 1 of 3 residents (R1) who were at risk for falls, which resulted in actual harm when R1 sustained a rib fracture as a result of a fall out of bed. The deficient practice was corrected prior to the start of survey, therefore was issued at past noncompliance. Findings include: R1's quarterly Minimal Data Set (MDS) dated 8/27/25, indicated R1 had diagnoses which included metabolic encephalopathy (a change in how your brain works due to an underlying condition, can cause confusion or memory loss), neurocognitive disorder with Lewy bodies (a progressive brain disorder), anxiety disorder, and severe cognitive impairment. Further, MDS revealed R1 had one fall without injuries since prior assessment. R1's care plan dated 5/23/25, indicated R1 was a fall risk due to history of falls, impaired gait and	F0656		

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F0656 SS = G	Continued from page 2 mobility, neurocognitive disorder with Lewy bodies, chronic heart failure, metabolic encephalopathy, and moderate protein calorie malnutrition. R1's care plan directed staff to check toileting needs every 2-3 hours initiated on 8/28/25, monitor and report when resident attempts to self-transfer from wheelchair initiated 7/22/25, floor mat next to bed initiated 8/28/25, sign in room reminding resident of need for assistance initiated 8/28/25, and soft touch call light placed under the sheets and under hip while in bed initiated on 8/29/25. R1's Incident Review and Analysis dated 6/26/25, indicated on 6/19/25 at 5:45 a.m., R1 was found on the floor. R1 was found sitting facing the door with legs straight and was on their roommate's mat with back against roommate's bed. Further, document identified new intervention following the fall was a floor mat to bedside was placed and the intervention was care planned. R1's Incident Review and Analysis dated 9/5/25, indicated R1 had a fall on 8/24/25, at 8:30 a.m., R1 was found sitting on the floor by his bedside with his back leaning on his bed, there were no injuries at the time of the fall. Further, document identified new intervention following the fall was a soft touch call light placed under hip while in bed. R1's Incident Review and Analysis dated 9/5/25, indicated R1 had a fall on 8/28/25, at 8:05 p.m. R1 had an incontinent episode and the brief was wet, R1 pulled apart his wet brief indicating his discomfort and toileting needs. R1 put on his call light to alert staff he slid out of bed. R1 was sitting on floor with back against the bed. R1 denied pain and discomfort. Further, document identified R1's care plan was not followed as there was not a floor mat next to R1's bed or in his room. R1's After Visit Summary from the Emergency Department (ED) dated 8/28/25, indicated reason for visit was a fall and diagnoses included fall, closed fracture of one rib of left side and contusion of left shoulder. ED summary indicated chest x-ray did not show any rib fractures or pneumothorax, but computed tomography (CT) scan of the chest was suggestive of acute left lateral 9th rib fracture. R1's progress notes revealed the following: -On 8/28/25, R1 put on his call light to inform staff that he was sitting on the floor. R1 had no injuries and vital signs were stable. Staff will send per family	F0656		

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F0656 SS = G	Continued from page 3 request to the ED as fall was unwitnessed. -On 8/29/25, R1 had complained of increased left shoulder pain and back pain. Pain was noted when transferring or using the left arm. -On 9/2/25, R1's family spoke with staff regarding concerns with resident's pain management. Family indicated they thought this weekend R1 was in more pain and needed different medications. Writer reviewed R1's chart with family and confirmed staff was assessing pain but R1 had not reported pain or discomfort. R1's Pain Level Summary revealed R1 had rated his pain a 9/10 on 8/29/25, at 9:00 a.m. On 9/10/25 at 3:56 p.m., nursing aid (NA)-A stated R1 had impaired cognition and required assistance with all activities of daily living (ADL) including transfers with a mechanical stand lift. NA-A stated R1 exhibited behaviors such as wandering and self-transferring. Further, NA-A stated R1 was identified as a high fall risk and staff had been instructed to keep R1's bed low, fall mat next to bed, and touch pad call light while R1 was in bed. NA-A stated she was assigned to care for R1 on 8/28/25, and at approximately 8:00 p.m. R1 put his call light on. NA-A entered R1's room and observed R1 sitting on the floor and ripping apart his brief. NA-A stated at the time of the fall, R1's care plan did not identify R1 required a floor mat, but NA-A stated he required a low bed. NA-A stated R1 did not appear to be in pain and R1 was assisted back into bed after being assessed by the nurse. In addition, following R1's incident education was provided to staff regarding care plan interventions and new interventions of floor mat, and touch pad call light were added to R1's care plan. On 9/10/25 at 4:47 p.m., NA-B stated if a resident was at risk for falls and had interventions this would be identified on the staff's care sheets which was updated by the director of nursing (DON). NA-B stated education was provided to the staff regarding care plan interventions and referring the care sheets if staff are unsure. On 9/10/25 at 5:10 p.m., R1 was not observed in his room, however his bed was along the wall next to the window, there was a call don't fall sign posted on his closet door, a floor mat that was folded and placed by the closet, and room appeared clean and free of clutter.	F0656		

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F0656 SS = G	Continued from page 4 On 9/10/25 at 5:12 p.m., NA-C stated R1 was identified as at risk for falls and some interventions staff were directed to use were low bed, floor mat, and placing the soft touch call light under R1 while he was in bed. Further, NA-C stated fall interventions were listed in each resident's care plan for staff to reference. On 9/10/25 at 5:20 p.m., licensed practical nurse (LPN)-A stated R1 had impaired cognition and was not able to verbalize his needs so staff anticipate needs. LPN-A stated R1 would get very restless occasionally and would attempt to self-transfer which put R1 at risk for falls. LPN-A stated staff were directed to place R1's bed low, floor mat, soft touch call light under hip while in bed. LPN-A stated R1 recently had a fall and sustained a rib injury but felt R1's pain had been well managed with scheduled Tylenol and R1 appeared to be comfortable. In addition, LPN-A stated all staff had education about care plans and following interventions after R1's fall. On 9/11/25 at 6:57 a.m., registered nurse (RN)-A stated R1 had impaired cognition and required staff assistance with all ADLs. RN-A stated R1 was at risk for falls. At approximately 8:05 p.m. on 8/28/25, R1's call light was on, and RN-A was then alerted by a NA R1 was on the floor. RN-A stated she entered R1's room and observed R1 sitting on the floor with his legs straight out in front of him and his back against the bed. RN-A stated R1 was wearing gripper socks, and his bed was in the lowest position at the time, but RN-A had noticed there was no floor mat under R1. RN-A assessed R1 and R1 did not appear to be in pain and no visible injuries were noted. RN-A stated R1 was sent to the ED per family request since it was an unwitnessed fall and R1 returned to the facility around 2:00 a.m., diagnosed with a rib fracture. Further, RN-A stated a floor mat had been an intervention for "some time" but RN-A was not sure on when she last seen the floor mat in R1's room. RN-A also stated management had discussed an intervention of the gray soft touch call light but that was not implemented or identified in R1's care plan at the time of the fall either. In addition, RN-A stated management provided all staff education on following care plan interventions for falls and alerting management if you are not seeing an intervention anymore that had been previously used. On 9/11/25 at 9:44 a.m., NA-D stated R1 was at risk for falls and staff were directed to keep him near nurse's station if he was restless or active, and if R1 was in bed he would require a low bed, fall mat which he has had "quite a while", and a touch pad call light	F0656		

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F0656 SS = G	Continued from page 5 underneath him too. Further, NA-D stated she was aware R1 had a fall and sustained a rib injury. Following R1's fall, NA-D stated the DON, and administrator called her and provided education related to resident specific fall interventions and what to do if staff notice an intervention was missing. On 9/11/25 at 11:51 a.m., interim director of nursing (DON) stated R1's cognition was impaired and R1 required staff assistance with all ADLs. DON stated R1 was at risk for falls and interventions to prevent falls included: toileting every 2-3 hours, concave mattress, room and floor clean, floor mat next to bed, two signs posted in his room to use call light for assistance, and soft touch call light to the right hip. Further, DON stated R1 had a fall on 6/19/25, with no injuries, and confirmed interdisciplinary team (IDT) determined a fall mat at R1's bedside was an appropriate intervention; however, DON confirmed the floor mat was not added to R1's care plan until 8/28/25. DON was unsure why the intervention was not added to R1's care plan immediately, but stated DON added the intervention as soon as we realized it was not identified in R1's care plan at the time of his fall on 8/28/25. DON stated R1 had another fall that occurred on 8/24/25, with no injuries, and IDT determined an appropriate intervention would be R1 to use a soft touch call light; however, R1's care plan was not updated until 8/29/25. DON stated all staff would not have been aware of those two interventions, the floor mat and the call light, at the time of R1's fall on 8/28/25, since they were not identified in R1's care plan and DON was unsure if the staff's care guide sheets were revised to include those at the time. DON stated following a fall, the floor nurse would notify the DON, and the DON and nurse would discuss root cause and determine an immediate intervention together. The DON stated then the IDT would meet every morning on business days and go through the risk management/incident reports, which the IDT then would determine an appropriate intervention, and DON would revise the care plan as well as inform the staff verbally to pass on in report and add to the care sheets the floor staff utilize. Review of facility policy titled Care Planning revised 11/24, indicated the care plan would be used in developing the resident's daily care routines and utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care would be utilized to provide care to the resident. The care plan was to be modified and updated as the condition and care needs of the resident changes.	F0656		

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F0656 SS = G	Continued from page 6 Review of facility policy titled Fall Prevention and Management revised 2/24, indicate following a fall nursing staff would complete an incident review and analysis. The IDT would review falls daily at morning meeting. When a resident falls, the following information should be recorded in the resident's medical record: interventions, first aid, or treatment administered, and appropriate interventions taken to prevent future falls. Further, follow up included care plans would be updated to reflect fall interventions. The facility implemented the following corrective action on 8/29/25 and this is being issued in past noncompliance. -R1's care plan was updated with current fall interventions, -All staff were educated on revisions and following care plans, if staff had questions or clarifications regarding interventions reach out to the floor nurse or DON -Audits weekly to ensure IDT interventions have been implemented and are in care plan -IDT process change to double check the intervention was added to the care plan and the care guide sheets prior to closing the risk management/incident report	F0656		

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/10/25 through 9/11/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure. The following complaint was reviewed during the survey. H54713262C (2604181) with no licensing order issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.	20000		08/29/2025

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

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20000	Continued from page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		