

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/25/2025
NAME OF PROVIDER OR SUPPLIER  The Waterview Woods LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  601 Grant Avenue Eveleth, MN 55734	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and document review, the facility failed to ensure ceiling tiles were maintained in a safe manner for 1 of 1 resident (R49) reviewed for environment. Findings include: R49's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition. Diagnoses included hypertension, hyperlipidemia and renal insufficiency. During observation on 7/24/25 at 11:08 a.m. R3's bathroom had a missing ceiling tile that was over the toilet. There was a wet towel draped across the hole and drooping down, exposing the area above the ceiling tiles. There was noted free standing water on the toilet itself. The white towel was stained with brown discoloration along with the middle areas saturated with moisture. During an interview on 7/24/25 at 11:10 a.m. R3 stated the ceiling tile has been missing and the towel in place for at least a month. He was told it was because of a leak of some kind from the room on the second floor, right above R3's room. During an interview on 7/24/25 at 12:18 p.m., housekeeper (HSK)-A stated the missing ceiling tile and towel over the tile has been that way for at least a month. There was some kind of leak in the room above this. It must still be leaking because when the room was cleaned this morning there was free standing water and the toilet paper on the back of the toilet had to be thrown away because it was soaked with water. During an interview on 7/24/25 at 1:28 p.m., the maintenance director (M)-A stated he was not sure how long the ceiling tile had been that way in R3's room. There was a leak in the toilet in the room above R3's room and that is where the water had come from. The leak had been fixed, and the towel was there to see if the leak was still there. During an interview on 7/24/25 at 12:40 p.m., the infection preventionist (IP) stated anytime wet towels were left hanging in rooms and there was free standing water in the room there was an increased risk of infection and other illnesses to be present. During an interview on 7/24/25 at 2:06 p.m., the regional director of operations (RDO) stated water leakage, and a damaged ceiling would lead to the resident being moved, water cleaned up, and the problem fixed prior to letting any resident back in the room. A policy for environmental services water leakage was requested but not provided.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on interview and document review the facility failed to ensure accurate doses of buprenorphine (an opioid pain medication) were administered to 1 of 3 residents (R1) investigated for a significant medication error. Findings include: R1's face sheet dated 7/24/25 indicated diagnoses included pathological fracture in neoplastic disease of left femur (left leg upper bone), malignant neoplasm of esophagus and aftercare for joint replacement. R1's medical record indicated R2 was cognitively intact. R1's physician orders dated 7/16/25, indicated an order for buprenorphine HCL sublingual 2mg tablet. Give 1mg (half a tab) under tongue three times a day. A picture of R1's medication card dated 7/16/25, showed an individual bubble packed 30-day card with 24 whole pills, one in each bubble. There were also 6 slots with holes to indicate 6 pills had been removed. The order on the card identified buprenorphine sub. 2 milligrams (mg). Place half a tab under tongue three times a day. Pharmacy to send full 2mg tablets. Nursing to cut to administer 1mg three times a day. R1's narcotic sign-out book page not dated, indicated an order of buprenorphine 2mg give half a tablet three times a day. The page indicated on 6 different occasions R1 received a whole tablet instead of the half tablet ordered. During an interview on 7/24/25 at 1:05 p.m., licensed practical nurse (LPN)-A stated if a whole pill was signed out there would be a dot with a line under it. If there was a half a tablet removed there would be 1/2 tab document in amount given and then a note which would indicate if the other half was thrown away or saved for the next dose. LPN-A reviewed R1's narcotic medication sign out sheet and stated the documentation showed R1 received one whole tablet each time a dose was given. During an interview on 7/24/25 at 1:44 p.m. the acting director of nursing (DON) stated nursing needed to follow the five rights (right medication, patient, dose, route and time). A half tablet should be documented as 1/2 and a whole tablet given would be documented as a dot with a line under it. Facility policy Medication Administration- General Guidelines last reviewed 2025, indicated nursing would follow the five rights and would triple check those rights during the medication administration process.</p>		