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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterview Pines LLC	1201 8th Street South Virginia, MN 55792

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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure voiced concerns about the provision of care were acted upon timely and resolved to help potentially prevent occurrences for 3 of 3 residents (R1, R4, R6) reviewed who had voiced concerns about care from a staff member. Findings include: A facility-reported Vulnerable Adult Maltreatment Report (i.e,, FRI) dated, 7/16/25, identified R1 reported being handled roughly by a nursing assistant (NA) the night prior. The report identified NA-A as the alleged perpetrator and outlined they had been terminated from the care center. The report continued and identified another resident (R6) had reported concerns about how NA-A had transferred them and, again, that NA-A was rough with cares. R1's admission Minimum Data Set (MDS), dated [DATE], identified R1 had moderate cognitive impairment but demonstrated no delusional thinking. On 7/24/25 at 11:27 a.m., R1 was interviewed and recalled the incident from the week prior. R1 expressed it involved a male staff member who she felt was rough when doing cares. R1 stated she was sleeping at night and then suddenly, Next thing I knew, I was against the wall. R1 stated the male staff member just rolled her over without waking her up which caused her to be startled and have some pain. R1 stated being moved by him without warning was upsetting adding aloud, It was too hard [how he moved her]. R1 stated she reported this concern to someone at the care center but was unsure whom.R1's Aeris History & Physical, dated 7/14/25, identified R1 was evaluated by the medical doctor (MD) who outlined, Patient' neurostatus [sic] has not changed but she does claim there was some roughness with her last night . claims that somebody beat her up at this time but it is vague . gave to social service director [ ] and they are going to investigate. No reported injury noted last evening but she does have palpatory tenderness . will do an x-ray at this time.When interviewed on 7/24/25 at 12:13 p.m., NA-B stated they had worked at the campus through their agency for approximately three or four months. NA-B stated they were aware R1 had reported someone had rough handled her, and verified they had worked the shift with NA-A on the date of the alleged incident. NA-B stated they had never physically seen NA-A be intentionally abusive to any residents, however, had reported some concerns prior about his care to other staff members. NA-B stated the resident's had reported concerns that NA-A would move too fast with cares and, as a result, NA-B had told NA-A he needed to slow down while providing care. At 12:52 p.m., a follow-up interview was completed with NA-B. NA-B explained they had first heard residents' concerns being expressed about NA-A as soon as I came here and started working several months prior. NA-B reiterated the comments by the residents started at the same time and expressed they felt it was already being addressed from appearances. NA-B stated several residents had complained about NA-A and his provided care and named R4. NA-B stated residents' comments were often about NA-A moving too fast and explained there had also been one incident where a resident who used a mechanical lift was left suspended up while NA-A left the room to get incontinence products which NA-B attributed to a lack of organization with cares and a need for additional training. NA-B stated NA-A could be not easy to talk to and help improve his cares as he seemed to take is sometimes personally. NA-B stated they felt the management was aware of these concerns, including from months' prior, as the charge nurse who often worked as aware of the concerns, too. NA-B stated multiple nurses who had worked with NA-A also, Say the same thing. NA-B reiterated the employee all of these concerns had been reported and/or observed with was NA-A. R4's quarterly Minimum Data Set (MDS), dated [DATE], identified R4 had moderate cognitive impairment but demonstrated no delusional thinking. On 7/24/25 at 2:20 p.m., R4 was interviewed about his services in the nursing home and responded aloud, Not great. R4 was questioned if he had any concerns about the care provided by NA-A he could recall to which R4 responded aloud, [NA-A] I had trouble with. R4 explained NA-A had never physically hurt him but rather just comes on strong and did not always explain cares or what he wanted adding, It's a demand thing by him. R4 added, I don't like that. R4 stated he had told the staff at the desk about these concerns but was dismissed with a boys will be boys response. R6 was discharged from the care center at the time of survey and unavailable for interview. During the abbreviated survey, a telephone interview was attempted with NA-A; however, they were unable to be reached. When interviewed on 7/24/25 at 1:43 p.m., licensed practical nurse (LPN)-A verified they routinely worked the overnight shift and had worked with NA-A. LPN-A stated they had never observed or had anyone report concerns about NA-A's care on the night shift prior adding, He was one of the nicest guys there ever was. The facility-provided WVP (Waterview Pines) Grievances listing, dated 1/1/25 to 7/25/25, identified all filed grievances along with each' respective incident