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	11/21/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to promote dignity and respect for 1 of 3 residents (R1) who required assistance with activities of daily living (ADLs) and reported rough and disrespectful care by staff.Findings include: R1's Entry Minimum Data Set (MDS) dated [DATE], identified admission to facility on 9/25/25, from an acute care hospital. R1's care plan (CP) dated 9/26/25, identified he was vulnerable to abuse and instructed staff to monitor for signs of emotional distress, mood or behavior changes and continue to follow the facility's Vulnerable Abuse Reporting policy and directed R1 was independent with activity choices and staff were to respect his choices of preferred room leisure time. CP also indicated R1 had an alteration in mobility related to colon cancer, edema (fluid retention), pain, and malnutrition with a goal he would move safely within his environment; staff were directed to assist with movement in bed and in/out of bed assist of one with front wheeled walker/wheelchair. R1 also had an alteration in mood, behaviors, and psychosocial well-being related to adjustment to facility and current health condition and staff were directed to reapproach R1 when he refused (cares, medications, linen changes to bed) with a soft tone and give him time and options, monitor and document mood state/behaviors upon occurrence, and provide emotional support, validation and comfort measures as needed (PRN). R1's progress notes from 9/26/25, identified: -at 10:32 a.m. R1 refused to allow nursing assistant (NA) and registered nurse (RN) on shift to complete cares and all scheduled medications. Writer went into resident room and spoke with him. He stated, can't you guys just let me sleep for a few more hours and come back. Writer said yes and asked if he had any pain or needed pain medication. He denied pain at that time. -at 7:36 a.m. On Hospice, laid in bed. Not willing to have a full body check due to pain. -at 3:15 p.m. Hydro morphine Hydrocholoride (HCL) 2 milligrams (mg) administered by mouth (po) every 1 hour as needed for low back pain and cancer.-at 6:14 p.m. Follow-up pain scale was 5 out of 10. PRN administration of Hydro morphine was ineffective. Review of the nursing assistant (NA) tasks documentation dated 9/26/25, identified: no behavior charting. During an observation on 10/2/25 at 8:50 a.m., NA-A offered to change his bed; he refused until later and exited the room. During an observation/interview on 10/2/25 at 8:55 a.m. R1 laid in a dark room on bed fully dressed covered with a blanket. R1 stated he was admitted to the facility on [DATE], and the stay had been ok, but the staff would not listen to him, and he was feeling upset about that. R1 had told staff when he was sleeping, he did not want to be bothered. R1 stated one afternoon, right after he was admitted to the facility, a staff NA was ruff with him while she assisted him. The NA moved his legs too fast and almost ripped out his drainage tube. He explained they did not get along or see eye to eye, and she lacked respect for his wishes. R1 stated there was also another female NA in the room when the incident occurred, adding the day it happened NA-A was told he did not want her in his room or taking care of him anymore, then today, she had been assigned to him. This was upsetting for him, and he did not want her in his room or caring for him. There was lack of respect and she refused to listen to what his needs were. He wanted to get back to sleep, not be bothered and would let staff know when he wanted his bed changed. During an interview on 10/2/25 at 9:44 a.m., director of nursing (DON) (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she had gone into R1's room along with NA-A and asked if he wanted to be washed up and dressed for the day and he requested to be left alone and allowed to sleep. She left early that day and was unaware of any concerns R1 may have had or that he did not want NA-A to care for him. During a follow-up interview on 10/3/25 at 11:15 a.m., DON stated she went back yesterday (10/2/25) and realized she had received an email from the floor manager RN-A on 9/26/25 at 3:44 p.m. which indicated MD stopped to see R1, heard him crying due to pain while cares were provided by two staff NAs. MD requested NA-A not be allowed to care for R1. DON stated if she would have been contacted that day she would have removed NA-A from the floor immediately, began an investigation, interviewed all residents she had taken care of, completed skin checks on all cognitively impaired residents, and if signs and symptoms of abuse or neglect were found, reported it within two hours to the state. She would have expected to be contacted by the floor manager RN-A right away. DON added, after she talked with R1 and learned the reason behind the pain was NA-A had moved to his legs too fast, he felt safe, not malicious attempt in any way, it was more of a care concern. DON stated she was unaware NA-A had previous history of discipline action taken with inappropriate behaviors (yelling in hallways, bulling other peers, HIPPA) that could be projected onto residents and mistreated them. Facility untitled document on 10/2/25, identified administrator and director of nursing (DON) were notified of possible rough cares with R1. Writer attempted to speak with R1 around 12:15 p.m. on 10/2/25, he appeared agitated, did not want to speak, was unable to breath and was in pain. R1 was assisted up into wheelchair, brought outside, and communicated he felt better. Interviews with intact cognition residents and skin checks were initiated on all residents. Administrator was notified by Minnesota Department of Health (MDH) surveyor R1 did not want NA-A, who the allegation was against, to care for him. NA-A was immediately given a new assignment and was not removed from the schedule. DON visited with R1, and he did not express any care concerns. Administrator received statements from the two NAs at time of allegation, there were no care concerns noted. During an interview on 10/2/25 at 10:08 a.m. NA-A stated on 9/26/25, around 2:30 p.m. she had entered R1's room along with NA-B and transferred him out of bed. NA-A cleaned up his bed and NA-B assisted R1 with cares and placed clean clothing on him. Together both NAs assisted him back into bed, he complained of pain, indicated the drainage tube had gotten pulled on and hurt. R1 stated out loud, you hurt me and my tube, we did not see anything happen to his tube. R1 repeated my tube hurts now. We were careful and the drainage tube may have rubbed up against something when in bed. No bleeding was noted and no complaints about how he was transferred. MD entered the room as she exited, unsure as to who he was. NA-A's shift was over and did not inform the nurse prior to leaving work that day. Things were going ok since that day; she had worked the following two days (Saturday and Sunday) alone with him, without any other staff in the room with her. She had apologized to R1 on Saturday morning and he did not seem angry, upset, or ask her to leave. The administrator just informed her they would have someone else to take care of R1 the rest of the day, she was not to go in his room and not told why. She was allowed to stay and work with other residents on the floor. During an interview on 10/2/25 at 11:00 a.m. medical doctor (MD) stated on 9/26/25 in the afternoon he had walked into the middle of a situation with R1 and a staff NA-A. R1 stated NA-A pulled on his catheter drain and almost ripped it off. The NA-A stated she was sorry that happened and would report it to the supervisor, R1 appeared teary eyed, visibly upset, obviously something happed that should have not, and needed to be investigated. NA-B interacted great with R1 and informed him she planned on reporting this to the supervisor. Prior to leaving the building he stopped at the front desk office off to the right of the front door and informed a staff that sat behind the desk NA-A was rough with R1 and she informed him she would investigate it. He was a mandated reporter and felt this was a situation that should have had follow up regarding rough handling. During an interview on 10/2/25 at 11:50 a.m. registered nurse (RN)-B stated she was loud at times while in R1's room and he had told her to get out frequently, refused cares and medications. She reapproached him and sometimes it had worked. On 9/26/25, NA-B informed her R1 had been man handled and (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed something for pain. R1 was visually upset and teary eyed, stated his drainage tube had been pulled, tube was assessed and intact. While she was in R1's room he stated he did not ever want that lady in there again and pointed to NA-A, was rough handled and his tube hurt. The incident occurred at the end of the day shift, NA-A went home, returned the following day and cared for R1 and other residents. RN-B stated she did not ask R1 if he felt safe or was ok with NA-A caring for him but was aware he had requested no further care by her. During an interview on 10/3/25 at 11:52 a.m., administrator stated they were not aware of the incident with R1 and NA-A until 10/2/25. Administrated indicated both NA-A and NA-B (witness) provided statements, they reviewed NA-A's personnel file and education was provided. We did not suspect abuse. NA-A lifted R1's legs too fast, possibly bumping his drainage tube and increased his pain. Education on professional boundaries and safe handling had been completed with NA-A on 10/2/25.During an interview on 10/2/25 at 2:40 p.m. NA-B stated she cared for R1 frequently and he required total assist of two person with cares. He had cancer and was terminally ill. He did not use his call light, they checked on him at least every two hours, and it was important to be quiet and calm when she entered his room. NA-B stated she arrived at work at 2:30 p.m. on 9/26/25, and received report from NA-A. R1 had not been touched all day and refused cares. NA-A requested assistance to try again. We entered R1's together and room smelled of bowel movement (BM) and urine (noted to be on the bed linens). She sent NA-A out of the room to gather linens. NA-B assisted R1 to stand up while she cleansed his front, back, bottom and placed clean clothing on him. NA-B re-entered the room and changed the linens on his bed. NA-A stood on R1's right side and NA-B stood on his left side, he grabbed under their arms, stood up, pivoted, and sat down on edge of bed. She took ahold of his shoulders and NA-A grabbed his feet. She counted three, two and before she could say one NA-A quickly swung his feet/legs up onto the bed, and was not gentle, adding she gave it all it was worth, not sure what [NA-A] was thinking. (he was a thin person, and legs were light). R1 started to scream and cry and stated his drainage tube got pull and was in pain. She informed NA-A she would finish. NA-A started to pick up dirty lines and was told to leave the room. NA-B reassured R1 and looked at the tube, no bleeding noted. MD was outside R1's door waiting to see him, walked into the room. She informed MD NA-A was a little rough with R1 while she placed his feet/legs onto the bed. MD informed her he did not want NA-A back in the room, the incident reported, and pain medication given now. R1 cried in pain. She walked down to the desk and talked with the nurse on duty requested pain medication to be given per MD. NA-B went down to the office located by the front of the building around 2:45 p.m. where two-unit managers were located. She informed them MD was in R1's room, upset and requested NA-A stay out of his room due to being rough with him and this incident needed to be reported. They responded ok and went back to work. MD came down the hallway and asked NA-B if she had informed the unit managers of the incident and she stated yes, and he thanked her. NA-B stated NA-A was rough with R1 but did not seem to be maliciously done. She had worked with NA-A for 15 years and not seen her treat any other resident that way, felt she was in a hurry and wanted to go home for the day. When R1's legs were grabbed and thrown onto the bed the drainage tube must have been located underneath, was hooked on something, and pulled. During an interview on 10/2/25 at 3:36 p.m., floor manager RN-A stated she had worked on 9/26/25 and heard R1 refused cares throughout the day and at shift change NA-A and NA-B completed R1's cares together. MD came to the office and informed her and another floor manager he did not want NA-A working with R1 anymore without explanation and walked out of the office. NA-B stopped in the office informed her MD did not want NA-A working with R1. RN-A stated she emailed the director of nursing (DON) later that afternoon with the information she had but now sees it would have been beneficial to have asked NA-B more questions. She was made aware he was in pain and resistive to care earlier in the day. Facility policy Combined Federal and State [NAME] of Rights dated 6/18/19, identified the resident has a right to a dignified existence, self-determination, and communication, and access to persons and services inside and outside the facility. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Facility policy Safe Resident Handling dated 3/2020, identified safe patient handling is a key component to reducing hazards of injury to our employees and our residents so that when residents receiving care require assistance from facility employees to move, assistance is provided in a manner that is safe to both the resident and employee. The facility is committed to provide high quality resident care. Facility document undated Professional Boundaries identified the employee-resident relationship was designed to meet the needs of the resident and protects the resident's dignity, autonomy, and privacy and allows for the development of trust. Professional boundaries are the spaces between the employee's power and the resident's vulnerability. Employees should make every effort to respect the power imbalance and ensure resident-centered relationships.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and document review the facility failed to thoroughly investigate an allegation of staff to resident abuse and protect residents during the investigation for 1 of 3 residents (R1) who reported a staff handled their care roughly, causing them pain. Findings include: R1's entry Minimum Data Set (MDS) dated [DATE], identified he was admitted to the facility on [DATE], from an acute care hospital. R1's care plan (CP) dated 9/26/25, identified he was vulnerable to abuse and instructed staff to monitor for signs of emotional distress, mood or behavior changes and continue to follow the facility's Vulnerable Abuse Reporting policy and directed R1 was independent with activity choices and staff were to respect his choices of preferred room leisure time. CP also indicated R1 had an alteration in mobility related to colon cancer, edema (fluid retention), pain, and malnutrition with a goal he would move safely within his environment; staff were directed to assist with movement in bed and in/out of bed assist of one with front wheeled walker/wheelchair. R1 also had an alteration in mood, behaviors, and psychosocial well-being related to adjustment to facility and current health condition and staff were directed to reapproach R1 when he refused (cares, medications, linen changes to bed) with a soft tone and give him time and options, monitor and document mood state/behaviors upon occurrence, and provide emotional support, validation and comfort measures as needed (PRN). During an observation on 10/2/25 at 8:50 a.m., NA-A offered to change his bed; he refused until later and exited the room. During an observation/interview on 10/2/25 at 8:55 a.m., R1 laid in a dark room on bed fully dressed covered with a blanket. R1 stated he was admitted to the facility on [DATE], and the stay had been ok, but the staff would not listen to him, and he was feeling upset about that. R1 had told staff when he was sleeping, he did not want to be bothered. R1 stated one afternoon, right after he was admitted to the facility, a staff NA was ruff with him while she assisted him. The NA moved his legs too fast and almost ripped out his drainage tube. He explained they did not get along or see eye to eye, and she lacked respect for his wishes. R1 stated there was also another female NA in the room when the incident occurred, adding the day it happened NA-A was told he did not want her in his room or taking care of him anymore, then today, she had been assigned to him. This was upsetting for him, and he did not want her in his room or caring for him. There was lack of respect and she refused to listen to what his needs were. He wanted to get back to sleep, not be bothered and would let staff know when he wanted his bed changed. During an interview on 10/2/25 at 9:44 a.m., director of nursing (DON) stated she had gone into R1's room along with NA-A and asked if he wanted to be washed up and dressed for the day and he requested to be left alone and allowed to sleep. She left early that day and was unaware of any concerns R1 may have had or that he did not want NA-A to care for him. During a follow-up interview on 10/3/25 at 11:15 a.m., DON stated she went back yesterday (10/2/25) and realized she had received an email from the floor manager RN-A on 9/26/25 at 3:44 p.m. which indicated MD stopped to see R1, heard him crying due to pain while cares were provided by two staff NAs. MD requested NA-A not be allowed to care for R1. DON stated if she would have been contacted that day she would have removed NA-A from the floor immediately, began an investigation, interviewed all residents she had taken care of, completed skin checks on all cognitively impaired residents, and if signs and symptoms of abuse or neglect were found, reported it within two hours to the state. She would have expected to be contacted by the floor manager RN-A right away. DON added, after she talked with R1 and learned the reason behind the pain was NA-A had moved to his legs too fast, he felt safe, not malicious attempt in any way, it was more of a care concern. DON stated she was unaware NA-A had previous history of discipline action taken with inappropriate behaviors (yelling in hallways, bulling other peers, HIPPA) that could be projected onto residents and mistreated them. During an interview on 10/2/25 at 10:08 a.m., NA-A stated on 9/26/25, around 2:30 p.m. she had entered R1's room along with NA-B and transferred him out of bed. NA-A cleaned up his bed and NA-B assisted R1 with cares and placed clean clothing on him. Together (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	both NAs assisted him back into bed, he complained of pain, indicated the drainage tube had gotten pulled on and hurt. R1 stated out loud, you hurt me and my tube, we did not see anything happen to his tube. R1 repeated my tube hurts now. We were careful and the drainage tube may have rubbed up against something when in bed. No bleeding was noted and no complaints about how he was transferred. MD entered the room as she exited, unsure as to who he was. NA-A's shift was over and did not inform the nurse prior to leaving work that day. Things were going ok since that day; she had worked the following two days (Saturday and Sunday) alone with him, without any other staff in the room with her. She had apologized to R1 on Saturday morning and he did not seem angry, upset, or ask her to leave. The administrator just informed her they would have someone else to take care of R1 the rest of the day, she was not to go in his room and not told why. She was allowed to stay and work with other residents on the floor. During an interview on 10/2/25 at 11:00 a.m., medical doctor (MD) stated on 9/26/25 in the afternoon he had walked into the middle of a situation with R1 and a staff NA-A. R1 stated NA-A pulled on his catheter drain and almost ripped it off. The NA-A stated she was sorry that happened and would report it to the supervisor, R1 appeared teary eyed, visibly upset, obviously something happed that should have not, and needed to be investigated. NA-B interacted great with R1 and informed him she planned on reporting this to the supervisor. Prior to leaving the building he stopped at the front desk office off to the right of the front door and informed a staff that sat behind the desk NA-A was rough with R1 and she informed him she would investigate it. He was a mandated reporter and felt this was a situation that should have had follow up regarding rough handling. During an interview on 10/2/25 at 11:50 a.m., registered nurse (RN)-B stated NA-B informed her R1 had been man handled and needed something for pain. R1 was visually upset and teary eyed, stated his drainage tube had been pulled, tube was assessed and intact. While she was in R1's room he stated he did not ever want that lady in there again and pointed to NA-A, was rough handled and his tube hurt. Whoever came across the situation would have been expected to report it to the DON. MD requested it be reported to upper management and should have adding, if he had gotten hurt or not, it cannot just be dismissed as an incident, whether valid or not and had to be investigated. She would have been expected to report the incident to the DON and administrator right away; she was busy, slipped her mind, and dropped the ball. She had brought this incident up during the employee meeting on 9/29/25, DON and administrator were there. The incident occurred at the end of the day shift, NA-A went home, returned the following day and cared for R1 and other residents. RN-B stated she did not ask R1 if he felt safe or was ok with NA-A caring for him but was aware he had requested no further care by her.During an interview on 10/2/25 at 1:00 p.m., administrator stated RN-B had just informed surveyor she had not reported the incident with R1 (9/26/25) until Monday 9/29/25, did not feel it would have been important due to NA-A would have not rough handled R1. She expected RN-B to have reported this incident immediately. All staff education on safe handling and reporting, resident and staff interviews, skin checks on cognitively impaired residents will be completed today. NA-A was interviewed today, moved to a different wing and allowed to care for other residents as an NA. DON had interviewed R1. During an interview on 10/3/25 at 11:52 a.m., administrator stated they were not aware of the incident with R1 and NA-A until 10/2/25. Administrated indicated both NA-A and NA-B (witness) provided statements, they reviewed NA-A's personnel file and education was provided. We did not suspect abuse. NA-A lifted R1's legs too fast, possibly bumping his drainage tube and increased his pain. Education on professional boundaries and safe handling had been completed with NA-A on 10/2/25.During an interview on 10/2/25 at 2:40 p.m., NA-B stated she cared for R1 frequently and he required total assist of two person with cares. He had cancer and was terminally ill. He did not use his call light, they checked on him at least every two hours, and it was important to be quiet and calm when she entered his room. NA-B stated she arrived at work at 2:30 p.m. on 9/26/25, and received report from NA-A. R1 had not been touched all day and refused cares. NA-A requested assistance to try again. We entered R1's together and room smelled of bowel movement (BM) and urine (noted to be on the bed linens). She sent NA-A out of the room to gather linens. NA-B assisted (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 to stand up while she cleansed his front, back, bottom and placed clean clothing on him. NA-B re-entered the room and changed the linens on his bed. NA-A stood on R1's right side and NA-B stood on his left side, he grabbed under their arms, stood up, pivoted, and sat down on edge of bed. She took ahold of his shoulders and NA-A grabbed his feet. She counted three, two and before she could say one NA-A quickly swung his feet/legs up onto the bed, and was not gentle, adding she gave it all it was worth, not sure what [NA-A] was thinking. (he was a thin person, and legs were light). R1 started to scream and cry and stated his drainage tube got pull and was in pain. She informed NA-A she would finish. NA-A started to pick up dirty lines and was told to leave the room. NA-B reassured R1 and looked at the tube, no bleeding noted. MD was outside R1's door waiting to see him, walked into the room. She informed MD NA-A was a little rough with R1 while she placed his feet/legs onto the bed. MD informed her he did not want NA-A back in the room, the incident reported, and pain medication given now. R1 cried in pain. She walked down to the desk and talked with the nurse on duty requested pain medication to be given per MD. NA-B went down to the office located by the front of the building around 2:45 p.m. where two-unit managers were located. She informed them MD was in R1's room, upset and requested NA-A stay out of his room due to being rough with him and this incident needed to be reported. They responded ok and went back to work. MD came down the hallway and asked NA-B if she had informed the unit managers of the incident and she stated yes, and he thanked her. NA-B stated NA-A was rough with R1 but did not seem to be maliciously done. She had worked with NA-A for 15 years and not seen her treat any other resident that way, felt she was in a hurry and wanted to go home for the day. When R1's legs were grabbed and thrown onto the bed the drainage tube must have been located underneath, was hooked on something, and pulled. During an interview on 10/2/25 at 3:36 p.m., floor manager RN-A stated she had worked on 9/26/25 and heard R1 refused cares throughout the day and at shift change NA-A and NA-B completed R1's cares together. MD came to the office and informed her and another floor manager he did not want NA-A working with R1 anymore without explanation and walked out of the office. NA-B stopped in the office informed her MD did not want NA-A working with R1. RN-A stated she emailed the director of nursing (DON) later that afternoon with the information she had but now sees it would have been beneficial to have asked NA-B more questions. She was made aware he was in pain and resistive to care earlier in the day. She was made aware he was in pain, should have laid eyes on R1, completed a skin assessment and interview with him prior to leaving that day to make sure he was safe. She knew R1 was resistive to care earlier in the day and did not think it was anything that needed to be reported. Facility policy Abuse Prohibition/Vulnerable Adult Policy dated 4/2025, identified investigation will begin immediately in accordance with Federal Law. Staff will take immediate and appropriate actions to prevent further abuse, neglect, exploitation, and mistreatment from occurring while the investigation is in progress. The investigation may include interviewing staff, residents, or other witnesses to the incident. Corrective action based on the investigation will be completed (e.g. change of procedure, training, discipline or discharge staff). The facility will provide proper follow up communication related to the incident across all shifts and to practitioners and resident representatives as applicable.