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	01/15/2026

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

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and document review, the facility failed to ensure a registered nurse (RN) was scheduled for a minimum of eight hours a day. This had the potential to affect all 67 residents who resided at the facility. This was at past non-compliance do to no RN coverage addressed in the last two quarterly staffing records.Findings include: Review of the facility Staffing Schedules dated 1/1/25 through 6/30/25, revealed there was no RN coverage for the following dates: 1/25/25, 1/26/25, 2/9/25, 3/22/25, 3/23/25, 4/5/25, 4/6/25, 4/19/25, 4/20/25, 5/3/25, 5/4/25, 5/17/25, 5/18/25, 5/26/25, 6/14/25, 6/28/25, and 6/29/25.During an interview on 1/13/26 at 3:43 p.m., the corporate administrator stated the facility had a lot of issues with higher and getting agency staff to work during the first part of the year. The facility was aware there were several days from 1/1/25 through 6/30/25 that did not have RN coverage as required. They daily staffing schedules for 1/1/25 through 6/30/25 were reviewed by the corporate administrator and facility administrator and confirmed there were no RN coverage on the dates listed.Facility staffing policy was requested but not provided.

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based interview and record review the facility failed to ensure psychotropic PRN (as needed) medication orders were timed limited to a duration of 14 days for 1 of 5 residents (R9) who was reviewed for psychotropic medications. Findings include: R9's quarterly Minimum Date Set (MDS) dated [DATE], indicated R9 was cognitively intact with diagnoses of anxiety disorder, major depression, diabetes, and chronic diastolic heart failure. MDS section N. indicated R9 received high risk anti-anxiety medications. R9's facility provided undated Care Plan identified focus areas and interventions to support and monitor R9's behavior and mental health needs related to diagnoses of depression, anxiety, insomnia. Upon entering the facility on 1/12/26 R9's electronic medical record (EMR) orders included the order: alprazolam take 0.5mg every 24 hours as needed (PRN) for increased anxiety. The ordered date was 9/15/20/25. The order did not have a stop date. Pharmacy Consult Recommendations included:-10/22/25: the resident has order for alprazolam 0.5 mg give one tab as needed q 24-hour prn without stop date. Please consider discontinuation or add stop date per CMS regulation. Provider documented response: disagree pt is stable at current dose will reevaluate at next appt. -9/17/25: alprazolam no stop date. Please consider add stop date or discontinuation per CMS SOM. Provider response on 9/23/25 requested follow-up with range mental health who manages med During an interview on 1/15/26 at 11:54 a.m., clinical manager licensed practical nurse (LPN-A) stated R9's alprazolam order needed to have a new script every 14 days. LPN-A stated they did notify the provider to send a new script to the pharmacy every 12 days. They tracked the notification in a calendar but did not enter any orders into the EMR or have record of orders they had requested the provider send to the pharmacy. During an interview on 1/15/26 at 11:58 a.m., the director of nursing stated all PRN psychotropic medications needed to have stop date every 14 days for provider review and reorder if needed. R9 should have had a stop order and a renewal order for their alprazolam. Nurse consultant was present and stated their facility policy allowed nursing to stop PRN medication at 14 days to trigger the provider to reorder the medication. The facility policy Psychotropic Medication Use dated 5/2025, outlined the following instruction for the use of PRN psychotropic use: psychotropic PRN medications are to be used to address acute or intermittent symptoms, or in an emergency and are limited to 14 days. If a provider believes the PRN order should be extended beyond 14 days, the provider must document rationale and duration in the medical record.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to review and revise the resident care plan to include chemotherapy, breathing problems and oxygen use for 1 of 3 residents (R31) reviewed for care planning.R31's quarterly minimum data set (MDS), dated [DATE], identified a diagnosis of congestive heart failure (CHF), rectal cancer, and atrial fibrillation.R31's care plan, dated 12/11/25, didn't contain a focus statement for coordination and care of R31's chemotherapy treatments, breathing problems or oxygen use.R31's provider orders, dated 1/12/26, didn't contain orders for oxygen use or the care and keeping of oxygen equipment.R31's Weights and Vitals Summary identified R31 was wearing oxygen via nasal cannula on dates when oxygen saturation levels were recorded starting on 10/29/25 through 1/15/26.R31's provider progress note dated 10/29/25, identified new orders related to CHF: repeat chest x-ray next week, monitor vital signs every shift for two weeks, monitor oxygen saturation every shift daily and as needed for two weeks, if 90 percent or less update provider, oxygen use during the day at two liters per minute (LPM) via nasal cannula while on chemotherapy, make sure oxygen is on at one LPM during the night. A provider progress note from 11/5/26, identified to continue to monitor oxygen use at two LPM via nasal cannula every shift, resident occasionally has nasal cannula not in nostrils.During an observation and interview on 1/12/26 at 3:35 p.m., R31 was observed wearing an oxygen cannula on his nose, the oxygen concentrator was set at one liter per minute (LPM) and R31 stated he wore oxygen daily.During an observation on 1/14/26 at 7:10 a.m., R31 was in bed sleeping, oxygen cannula was on his nose, and the concentrator was running. During an interview on 1/14/26 at 12:23 p.m., licensed practical nurse (LPN)-B stated R3 occasionally wore oxygen.During an interview on 1/14/26 at 2:36 p.m., the director of nursing (DON) stated continuous and as needed (PRN) oxygen should have orders for them. The DON also stated she thought R31 had an order for oxygen because they were working on weaning him down and making sure his saturations stayed in an acceptable range.During an interview on 1/15/26 at 9:23 a.m., physical therapy assistant (PTA)-E confirmed he had been working with R31 since his admission, and R31 had been wearing oxygen when PTA-E was working with him, he thought R31 was currently on one LPM and checked his oxygen saturation levels while working with him. During an observation on 1/15/26 at 9:33 a.m., R31 was wearing oxygen via nasal cannula connected to an oxygen concentrator. During an interview on 1/15/26 at 10:28 a.m., LPN-A who was the clinical manager for R31, stated she would want orders in place if the resident was using oxygen. LPN-A confirmed R31's medical record didn't contain orders for oxygen.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a resident who was unable to perform their own activities of daily living (ADL)s received nail care for 1 of 3 residents (R44) reviewed for ADLs.R44's quarterly minimum data set (MDS), dated [DATE], identified significant cognitive impairment and a diagnosis of late-onset Alzheimer's dementia. The MDS further indicated R44 was dependent in all ADLs. R44's care plan, dated 8/6/25, identified a focus statement for assistance with ADLs related to dementia, osteoarthritis, weakness and falls. Interventions included an assist of one with all ADL tasks including nail care, specifically to trim fingernails and toenails as needed on shower days. The care plan didn't include podiatry care for her toenails, nor did it address behavior or resistance to having nails trimmed. R44's provider orders, dated 8/6/25, identified an order to check fingernails and toenails once a week and provide nail care every Wednesday. Document in nursing note of any behaviors or refusals. R44's electronic medical record (EMR) didn't contain a progress note related to bathing, nail care or refusals of nail care on Wednesday 1/7/26. An assessment, Weekly Skin Inspection dated 1/7/26, identified R44 had a bath or shower and had her finger and toenails trimmed. During an observation and interview on 1/13/26 at 1:39 p.m., family member (FM)-D stated he was having issues with R44's nails not being taken care of, and unbeknownst to him was removed from the podiatry list so her nails didn't get taken care of. FM-D stated he had looked at R44's feet in the first place because she was complaining of foot pain, and he found the great toes each had about one inch overhang from the end of the toe. FM-D also stated he had told the nursing home in writing to put her back on the podiatry list and he had talked to the administrator about it. At 1:49 p.m., FM-D opened R44's hands, as her fingers were pulled in close to her palm, and remarked her fingernails were at least one-quarter inch long, there was brown matter under some of the nails, other nails appeared to be stained. FM-D stated he didn't like to see them like this and thought they needed a trim. During an interview on 1/13/26 at 3:28 p.m., nursing assistant (NA)-E stated they would be responsible for trimming resident nails for non-diabetics only, the diabetics were done by the nurse. During an interview on 1/13/26 at 3:31 p.m., licensed practical nurse (LPN)-C stated R44's toenails were too thick for them to cut, but they could do her fingernails. During an observation and interview on 1/13/26 at 3:35 p.m., LPN-A, who was the clinical nurse manager for R44, stated R44 screamed bloody murder when they tried to trim her nails, and her family was aware of that. LPN-A stated she would expect nail care was done if it was documented as done. LPN-A looked at R44's fingernails and stated they were long and dirty as well. LPN-A stated she would have expected a nursing note and a notice to herself if R44 were refusing. During an interview on 1/13/26 at 3:58 p.m., the director of nursing (DON) stated she expected resident nails to be trim and clean. The DON explained she would have expected the nurse to have made a note if a resident were refusing care.Activities of Daily Living (ADL)s and Maintain Abilities Policy dated 3/31/23, identified a resident who was unable to carry out ADLs would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure orders were in place for a resident receiving oxygen for 1 of 7 residents (R31). In addition, the facility failed to assess and treat lower extremity edema for 1 of 7 residents (R23) reviewed for quality of care. Findings include: R31: R31's quarterly minimum data set (MDS), dated [DATE], identified a diagnosis of congestive heart failure (CHF), rectal cancer, and atrial fibrillation. R31's care plan, dated 12/11/25, didn't contain a focus statement for breathing or oxygen use. R31's provider orders, dated 1/12/26, didn't contain orders for oxygen use or the care and keeping of oxygen equipment. R31's Weights and Vitals Summary identified R31 was wearing oxygen via nasal cannula on dates when oxygen saturation levels were recorded starting on 10/29/25 through 1/15/26. During an observation and interview on 1/12/26 at 3:35 p.m., R31 was observed wearing an oxygen cannula on his nose, the oxygen concentrator was set at one liter per minute (LPM) and R31 stated he wore oxygen daily. During an observation on 1/14/26 at 7:10 a.m., R31 was in bed sleeping, oxygen cannula was on his nose, and the concentrator was running. During an interview on 1/14/26 at 12:23 p.m., licensed practical nurse (LPN)-B stated R3 occasionally wore oxygen. During an interview on 1/14/26 at 2:36 p.m., the director of nursing (DON) stated continuous and as needed (PRN) oxygen should have orders for them. The DON also stated she thought R31 had an order for oxygen because they were working on weaning him down and making sure his saturations stayed in an acceptable range. During an interview on 1/15/26 at 9:23 a.m., physical therapy assistant (PTA)-E confirmed he had been working with R31 since his admission, and R31 had been wearing oxygen when PTA-E was working with him, he thought R31 was currently on one LPM and checked his oxygen saturation levels while working with him. During an observation on 1/15/26 at 9:33 a.m., R31 was wearing oxygen via nasal cannula connected to an oxygen concentrator. During an interview on 1/15/26 at 10:28 a.m., LPN-A who was the clinical manager for R31, stated she would want orders in place if the resident was using oxygen. LPN-A confirmed R31's medical record didn't contain orders for oxygen. R23: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R23's admit Minimum Data Set (MDS) dated [DATE], indicated R23 was moderately cognitively impaired with diagnoses of venous insufficiency, acute respiratory failure, and ischemic cardiomyopathy. R23's undated facility provided Care Plan included focus area: Alteration in skin integrity with interventions: monitor skin during cares, weekly skin inspection by nurse, tubi grips on in a.m. and off in h.s. [bedtime]. R23's Order Summary Report dated as of 1/15/2026, included the following orders:-Tubi grips [material designed to provide compression and reduce swelling] on in a.m., off at H.S. every morning and at bedtime related to acute combined systolic and diastolic congestive heart failure. -Weekly skin inspection by licensed nurse. Complete MHM Weekly Skin In section in PCC every day shift every Thursday.-Orders did not include treatments or lotions for legs. R23's Treatment Administration Record (TAR) for the month of January 2026, had documented entries between 1/1/26 and 1/14/26, were signed off to indicate R23's tubi grips had been put on in the a.m. and removed at bedtime. R23's ordered Weekly Skin Inspection were documented as follows in the electronic medical record (EMR): -11/13/25: Res skin is dry and intact -11/28/25: did not see skin but NA had her dressed and said there was no issues. edema lower legs -12/10/25: BLE edema, no weeping noted from legs, scabs. No other skin issues noted -12/18/25: Edema bilateral lower extremities which are reddened but not weeping at this time. Dry scaly skin on legs. No other skin issues noted. -12/25/25 Edema bilateral lower extremities which are reddened but not weeping at this time. Dry scaly skin on legs. 12/31/25 entry: No new skin issues. Skin is dry warm and intact -1/8/26 no new skin issues skin is dry warm and intact During an interview on 1/12/2026 at 5:23 p.m., R23 was wearing knee high socks and was seated in a recliner with legs elevated. R23 stated they had bad edema in their legs and indicated their family member (FM-A) was the one who took care of their legs. Their legs had been really big and leaking fluid before, but now the fluid was way down and their legs hurt less. R23 stated they didn't really have any treatments for their legs other than a water pill. During an interview on 1/12/26 at 6:00 p.m., both R23 and FM-A were present. R23 stated FM-A cared for their legs not the nurses. FM-A, was not sure what the nurses did, but confirmed they did care for R23's legs during daily visits. FM-A stated R23's legs still had dryness and edema, and scabs (pointed to several scabs on R23's left leg -skin on leg was dry with flakes of skin) but overall R23's legs were much improved. R23 stated she liked to wear their white socks because they were absorbent and comfortable. FM-A stated they had bought the socks for R23 and indicated they were just cotton, not compression socks. During an observation on 1/13/26 at 9:42 a.m., R23 was seated with white knee-high socks on. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/13/26 at 2:15 p.m., R23 was seated with legs elevated wearing white knee-high socks. R23 stated they had kept their socks on from yesterday, nobody had offered to put tubi grip sock for them this a.m. R23 stated they had worn compression tubi things before but could not recall when they had last worn them. No tubi grips were visible in R23's room or bathroom. During an observation on 1/13/26 at 4:14 p.m., R23 was seated in recliner with the same knee-high socks on. During an observation on 1/14/26 at 7:16 a.m., R23 was seated in recliner, feet up, wearing the same knee-high socks. During an observation on 1/14/26 at 8:06 a.m., R23 remained in room with same knee-high socks on. During an observation on 1/14/26 at 11:58 a.m., R23 was being wheeled down the hall wearing the same white knee-high socks. R23 stated they were off to an appointment. During an interview on 1/14/26 at 3:13 p.m., licensed practical nurse (LPN-B) explained when they initialed something in the TAR it meant the task or treatment had been completed. LPN-B stated they had signed off on R23's tubi grips because they thought that R23 had been wearing them, but now they guessed they had not been on. LPN-B stated it was important for R23 to wear tubi grips because it helped prevent deep vein thrombosis (blood clots). During an interview on 1/14/26 at 3:15 p.m., the director of nursing (DON) stated when a task was signed off in the TAR it meant that task was completed. If a task was refused or not completed, they expected charting would reflect that. During an observation on 1/15/2026 at 9:45 a.m., R23 was seated in their recliner wearing their white knee-high socks. NA-D responded to R23's call-light and assisted R23 to the bathroom. During an after-care interview NA-D stated R23 did not wear tubi grips or anything like that. During an interview on 1/15/26 at 9:55 a.m., R23 was wearing white knee-high socks and stated staff had not offered to put any tubi compression things on them that morning. R23 stated their legs were more swollen today because of their appointment yesterday but overall, they felt their legs were much better. R23 indicated the staff didn't do any treatments to their legs, it was FM-A who had been washing and putting some kind of cream on their legs each day when they visited. During an interview on 1/15/26 at 11:44 a.m., clinical manager LPN-A opened R23's chart and stated R23 was not being tracked in wound care because R23 did not have any active wound treatments. Instead R23's leg issues were being tracked in the weekly skin assessments. LPN-A reviewed documented skin assessments and stated they would expect skin assessments to reflect skin changes like new scabs and ideally old scabs and/or other ongoing skin issues. Details were important to determine improvement or worsening skin status. Although R23 did not have orders for lotion application to dry skin, it was expected that NAs would identify and apply lotion to dry skin as part of their routine care of residents. LPN-A confirmed R23 had an order for tubi grips and confirmed charting showed that R23 had been wearing tubi grips each day in January as ordered. It was important for R23 to wear the tubi grips because of the fluid retention R23 had in their lower legs. LPN-A indicated they were not aware R23 had not been wearing their tubi grips and stated they expected staff to document a task as not done if it was not done and communicate to them if it was ongoing so it could be addressed. During an interview on 1/15/26 at 12:05 p.m., the DON stated they expected skin inspection documentation to include descriptive findings of old and healing wounds as well as any new edema, weeping, scabs, or any other area of concern so the information could be (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	used to implement or change treatments accordingly. When tubi grips are ordered, clinical managers should make sure the tubi grips are in the room and being applied as part of their resident monitoring oversight. Nurses are also responsible to ensure TAR orders are followed and should note if a resident is or is not wearing their tubi grips when they go into the resident's rooms and then document accordingly. The facility policy Skin Assessment & Wound Management dated 2/2025, included direction for daily skin inspection with cares, weekly skin inspection by licensed staff, implementation of appropriate preventive measures and referrals, notification and or update to provider, nurse, and family for new or ongoing skin issues as needed, care plan updating as needed, and to provide care and treatments as ordered.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure portable oxygen tanks were safely transported and/or secured for 1 of 2 residents (R23) reviewed for oxygen safety. Findings include: R23's admit Minimum Data Set (MDS) dated [DATE], indicated R23 was moderately cognitively impaired with diagnoses of venous insufficiency, acute respiratory failure, and ischemic cardiomyopathy. R23's Care Plan included focus area: Alterations in oxygen/gas exchange with oxygen use as ordered. R23's Order Summary Report dated as of 1/15/2026, included the following orders: Check portable oxygen/stroller every shift and fill if needed, and Oxygen Delivery System via 2LPM nasal cannula continuously for diagnosis acute respiratory failure with hypoxia. R23's Treatment Administration Record for the month of January 2026, had documented entries between 1/1/26 and 1/14/26,that indicated staff had checked R23's portable oxygen/stroller every shift and filled if needed. During an interview on 1/12/2026 at 5:23 p.m., R23 was seated in a recliner. R23's oxygen was connected to a large oxygen concentrator in the room. There was a free standing portable green cylinder oxygen tank located to the left of the concentrator sitting upright and directly on the floor. Both R23 and R23's family member (FM-A) stated the oxygen tank had been directly on the floor like that for a long time. Nursing assistant (NA-C) delivered R23's dinner tray and left the room. During an oxygen follow-up interview on 1/12/26 at 5:46 p.m., NA-C looked in R23's room and confirmed there was a free-standing unsecured oxygen tank directly on the floor in R23's room and stated they would need to get the RN because it was not safe to have an oxygen tank sitting in the room like that. Registered nurse (RN-B) entered R23's room, picked up the tank and carried it out of the room. During a follow-up interview on 1/12/26 at 6:30 p.m., RN-B stated they had removed the tank from R23's room and secured it in their oxygen storage area because unsecured oxygen created many safety risks. During an interview on 1/15/26 at 11:30 a.m., the director of nursing stated oxygen tanks should not be carried or left unsecured in the building due to the safety risks associated with oxygen tanks. The DON indicated they expected staff to use a wheeled oxygen tank carrier when they transported oxygen tanks. Staff were also expected to ensure oxygen tanks were secured in appropriate holding devices at all times. The facility policy on safe oxygen storage and handling was requested but not received.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to monitor fluid intake for a resident on a fluid restriction and on dialysis. This effected 1 of 2 (R8) residents reviewed for dialysis.Findings include: R8's admission Minimum Data Set (MDS) dated [DATE] indicated R8 was cognitively intact. Diagnoses included anemia, coronary artery disease, and end stage renal disease. R8 received hemodialysis while at the facility. R8 care plan dated 12/11/25, indicated risk of complications related to dialysis. Interventions included fluid restriction per order. The care plan also indicated a potential alteration in nutrition related to end stage renal disease on a 1500 milliliter (ml) fluid restriction. R8's Order Summary Report (OSR) dated 12/10/25, indicated a provider order for 1500 ml per 24 hours was entered. 600 ml came from nursing and 900 ml came from dietary Review of R8's Treatment Assessment Report (TAR) from 12/10/25 to 1/14/25 indicated there was a fluid restriction of 1500 ml every 24 hours that needed documented on every shift. The TAR also indicated the following: Not applicable (NA) was entered 27 times in December and 15 times in January for nursing and dietary intakes.An x was entered two times in December and 6 times in January for nursing and dietary intakes.The spot was left blank 3 times in December and one time in January for nursing and dietary intakes During an interview on 1/14/26 at 11:55 a.m., the dialysis center registered nurse (RN)-A stated R8's dry weights (weights after fluid removed during dialysis) were not getting reached. She had low blood pressures which made it difficult to get all the fluid off. There are several reasons that can cause this, but excess fluid intake is one of them. It is important to accurately monitor R8's fluid restriction because of the need to get all fluid off the patient without compromising the patient. During an interview on 1/15/26 at 10:03 a.m., nurse assistant (NA)-A stated all residents on a fluid restriction would be noted on their care plans. The total amount would be separated by how much nursing gave and how much dietary gave. Nursing would enter the total amount of fluid drank each shift when they were eating in their rooms. The nurse assistant was responsible to keep track of the fluid intakes and give them to the nurse to document in the medical record. NA-A did acknowledge R8 was on a 1500 ml fluid restriction. During an interview on 1/15/26 at 10:10 a.m. RN-B stated the aides gathered the fluid intakes for each shift and then gave them to the nurse to enter. The nurse would enter zero of nothing was taken in by nursing or dietary for the shift they were documenting on or enter the exact amount drank if fluid intake occurred. During an interview on 1/15/26 at 10:15 a.m., RN -C stated nursing was responsible for documenting all intakes for the residents in the medical record. There should always be a number entered into each slot on the chart. NA, an x and blank spots were not supposed to be there when a resident was on a fluid restriction. During an interview on 1/15/26 at 10:34 a.m. the director of Nursing (DON) stated all staff should be documenting accurate fluid intakes each shift when a resident is on a fluid restriction. Facility policy Fluid Restriction Guidelines last dated 9/12, indicated fluid intakes would be measured every shift per policy of facility.

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	01/15/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to perform appropriate hand hygiene while doing a brief change. The facility also failed to utilize appropriate personal protective equipment (PPE) for a resident in enhanced barrier precautions. This affected 2 of 5 resident (R54, R6) reviewed for infection control.Findings include: R6: R6's significant change Minimum Data Set (MDS) dated [DATE], identified he had diagnoses which included chronic obstructive pulmonary disease (a progressive lung condition that blocks airflow, making it hard to breath), right foot drop, spinal stenosis lumbar region with neurogenic claudication (nerve compression in the lower back from a narrowed spinal canal, causing symptoms like leg pain, cramping, numbness, or weakness that worsen with standing/walking), heart failure (the heart can't pump enough oxygen-rich blood to meet the body's needs), hypertension, and opioid dependence. In addition, R6's MDS identified he was cognitively intact and was dependent on staff for assistance with activities of daily living (ADLs). R6's MDS identified he was frequently incontinent of bowel. R6's care plan dated 12/9/25, identified R6 was on enhanced barrier precautions related to wounds and foley catheter. Interventions included to don and doff personal protective equipment when providing high contact cares. R6's Active Orders as of 1/15/26, identified he had orders for enhanced barrier precautions while providing wound cares and other high contact care activities dated 12/9/25. During an observation on 1/13/26 at 1:25 p.m., nursing assistant (NA)-F entered R6's room, with a non-powered manual sit-to-stand transfer aid (NA-F was not wearing an isolation gown). NA-F closed the curtains, lowered the bed, prepared the bed with a lift sheet, put on gloves put did not put on an isolation gown and positioned R6 to use the transfer aid. After assisting R6 into the bed, NA-F gave R6 the call light, removed gloves, performed hand hygiene and took the transfer aid out of the room. NA-G and NA-F entered the room, both donned gloves, no isolation gowns and proceeded to complete a brief change (incontinent of stool). NA-F called for a nurse to check skin and to complete dressing changes. The director of nursing (DON) entered the room, she had gowned and gloved prior to entering the room. The DON performed the dressing changes, doffed the gown and gloves in the room, washed her hands with soap and water and exited the room. NA-F had removed her gloves after the brief change and washed her hands. NA-F put new gloves on and emptied R6's foley catheter. NA-F removed her gloves and performed hand hygiene before exiting the room. During an interview on 1/13/26 at 1:57 p.m., the DON verified the NAs should have been wearing isolation gowns when they were completing personal cares for R6 related to his foley catheter and wounds. Enhanced Barrier Precautions dated 4/1/24, identified It is the practice of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. The policy identified staff would wear gowns and gloves during high-contact resident care activities for residents known to be colonized or infected with a multi-drug-resistant organism (MDRO) as well those at increased risk of MDRO acquisition. Examples given were those residents with wounds or indwelling medical devices. High-contact resident cares included transferring, providing hygiene and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changing briefs. R54: R54's quarterly Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment, incontinence of bowel and bladder, and maximal assist to dependent for toileting, hygiene and cares. Diagnoses included non-traumatic brain dysfunction and dementia. During observation on 1/14/26 at 8:38 a.m., nurse assistant (NA)-B entered R54's room to change clothes, do a brief change and get up in chair. NA-B gathered all needed equipment and placed on the bedside table. Hands were washed and clean gloves were placed on hands. The dirty gown was pulled down to the chest level, and the upper body was washed across the shoulders, neck and upper torso. The dirty gown was then completely removed from the resident, and a clean shirt was placed on the resident. Hands were not washed, and gloves were not changed at any time when going from dirty to clean. NA-B then gathered pants and placed them on the resident, pulling just up to the knees, still wearing the same dirty gloves. The brief was removed and peri care performed. Ointment was applied to the buttocks after cleaning. A clean brief was placed under the resident. NA-B removed the right-handed glove and proceeded to complete the brief change, touching the brief and peri area with the ungloved right hand several times. NA-A also came in contact with the dirty linens on the bed with the ungloved right hand. The Glove on the left hand was then removed. Without gloving, NA-B rolled R54 side to side, pulling the pants up the rest of the way, and removed all of the dirty linens under R54 with ungloved hands. New gloves were then put on without washing hands, the lift sling was placed under R54 and R54 was transferred from the bed to the chair. R54 was then taken to the hallway and setup for breakfast. Gloves were removed and hand sanitizer was used at that time. During an interview on 1/14/26 at 10:03 a.m., nurse assistant (NA)-B stated hands should be washed and new gloves put on when going from the dirty part of cares and start of clean part of cares. Gloves should never be removed and cares performed with ungloved hands. NA-B acknowledge she did not change gloves during cares and removed a glove and completed a brief change with an ungloved hand. During an interview on 1/15/26 at 10:03 a.m., the infection preventionist/director of nursing (IP) stated gloves needed to be changed and hands washed anytime they were going from dirty to clean when providing peri care. Example given was when the staff finished brief removal and cleaning of the peri area, hands would need to be washed, and gloves changed before placing the new clean brief on the resident. Facility policy Handwashing Policy last revised 2/24, indicated proper hand-washing techniques would be used to protect the spread of infection. Hand washing would be completed after changing incontinent products or cleaning up after someone who has used the toilet. The policy lacked information about hand hygiene when doing cares and placing clean items on right away.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on interview and document review, the facility failed to ensure the past three years of recertification and complaint survey results were available for review. This had the potential to affect all 67 residents residing in the facility, as well as family, visitors and staff.Findings include: On 1/12/26, at 7:27 p.m., a review of the survey binder was completed. Upon review of the survey binder, it was noted that all required recertification surveys, as well as complaint investigation surveys were present, with the exception of the recertification and complaint surveys for the year 2023. During an interview on 1/13/26 at 3:34 p.m., the administrator stated there should be three years of recertification and complaint surveys available for all residents, family and visits to view when wanted. the administrator stated she had just gone through the survey binder a month ago and made sure all needed surveys were in the binder.During an interview on 1/13/26 at 3:48 p.m., the corporate administrator reviewed the survey binder and confirmed all surveys from 2023 were missing and should be in there. A facility policy about the survey binder was requested but not provided.