STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245471	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterview Shores LLC	402 - 13th Avenue Two Harbors, MN 55616

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** 43083 Based on observation, interview, and document review, the facility failed to ensure residents were assisted with activities of daily living (ADLs) in a dignified manner for 2 of 2 residents (R2, R3) reviewed. Findings include: R2 R2's admission Minimal Data Set (MDS) dated [DATE], indicated R2 had diagnoses of cerebral infarction (stroke) and anxiety disorder. R2's care plan dated 10/4/24, indicated R2 had a self-care care deficit related to ischemic stroke and required staff assistance with personal hygiene. R2's care plan was revised 11/6/24 (after survey entrance), indicated R2 would often refuse to have facial hair removed when offered, this had been a long-standing preference from before admission to the facility. Further R2's care plan revised on 11/6/24, directed staff to offer assistance in removing facial hair and respect resident's right to refuse this service. R2's care plan lacked evidence of shaving preference prior to the start of survey. R3 R3's annual MDS dated [DATE], indicated R3 had diagnoses of traumatic brain injury (TBI), mood disorder, and dysphagia (difficulty swallowing). R3's care plan last reviewed on 8/12/24, indicated R3 required staff to assist with eating as needed due to vision. During an observation on 11/5/24 at 12:10 p.m., R3 was observed sitting in a standard wheelchair at a table in the commons area by the nursing station. NA-A was standing to the left of R3, and NA-A was noted to have her left hand on her left hip while physically feeding R3 with her right hand. NA-A was visiting with R3 while assisting her with eating. At 12:18 p.m., NA-A continued to stand over R3 and assisted R3 with noon meal. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/5/24 at 12:27 p.m., R2 was observed self-propelling down the hallway in her standard wheelchair towards her room. R2 was noted to have many visible white/gray whiskers on her chin. During an observation and interview on 11/5/24 at 12:37 p.m., R2 was laying in her bed and appeared comfortable. R2 stated staff assist her with bathing, dressing, toileting, and hygiene. When asked if staff assist R2 with shaving, R2 placed her right hand up to her chin and stated, I like to be shaved, I don't like whiskers. R2 stated staff did not offer to help her shave today. R2 was noted to have multiple long white and gray whiskers on her chin that would be visible to other people. During an interview on 11/5/24 at 1:46 p.m., NA-A stated she had worked with R2 in her previous living situation and stated R2 would allow staff to assist with ADLs. NA-A stated R2 required staff assistance with toileting, transferring, dressing, and hygiene. Further, NA-A stated staff were expected to assist each resident with shaving, however R2 doesn't want me to touch her face. NA-A stated R3 required staff assistance with eating due to R3 being unable to hold onto the utensils. NA-A stated when assisting a resident with a meal, NA-A did not sit due to multitasking with other things. During an interview on 11/5/24 at 4:21 p.m., NA-B stated staff were expected to ask each resident and assist with shaving if staff noticed any whiskers and each resident had their own razor. NA-B was not familiar with R2 and did not assist her often. Further, NA-B stated R3 required staff assistance with eating. NA-B stated staff attempted to sit with the resident when they were assisting with their meal. During an interview on 11/5/24 at 6:34 p.m., NA-C stated staff were expected to ask and offer each resident assistance with shaving and each resident has their own razor. Further, NA-C stated if a resident were to refuse, staff were expected to report to the nurse and chart the refusal in the resident's record. During an interview on 11/6/24 at 8:18 a.m., licensed practical nurse (LPN)-A stated R2 did not have a history of refusing cares or staff assistance however, LPN-A stated she was informed by a NA that R2 did not want to be shaved. LPN-A confirmed she observed R2's whiskers and did not offer to assist R2 because she did not want to make R2 feel bad. LPN-A stated staff were expected to offer a resident assistance with shaving when they observed it was needed or on shower days. Further, LPN-A stated R3 required staff assistance with eating, and staff were expected to sit next to R3 while assisting her and not towering over her, and staff should be having conversation with R3 during the meal. During an interview on 11/6/24 at 8:53 a.m., interim director of nursing (DON) stated staff were expected to re-approach or provide education to a resident if the resident were to refuse any cares, as well as chart in the resident's behavior tracking on refusals. DON stated if a resident were to have a history of refusals, the resident's care plan would be updated to reflect the history of refusals and interventions in place for staff to implement. Further, DON stated she was not very familiar with R2 however, confirmed R2's medical record did not have any documentation of R2 refusing assistance with shaving and R2's care plan lacked evidence of R2's shaving preferences. Further, DON stated staff were expected to be seated next to the resident at their level and having a conversation with the resident while assisting them with their meal. DON stated sitting at the resident's level was less intimidating to the resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 11/6/24 at 11:20 a.m., R2 was observed in her room laying in bed while reading the newspaper, and there were no visible whiskers on her chin. R2 stated staff just assisted her with shaving and she felt much better. During an interview on 11/6/24 at 11:23 a.m. LPN-A confirmed she had asked R2 if she would like to be shaved and R2 actually wanted it done. LPN-A stated she had asked R2 about shaving and R2 stated she would like to be shaved every two- three days. Review of facility policy titled Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, indicated the intent of the policy was to create and sustain an environment that humanized and individualized each resident's quality of life by ensuring all staff understand the principles of quality of life, and care and services provided are person-centered, and honor and support each resident's preferences, choices, values, and beliefs. Further, policy indicated facility would provide care and services for the following ADLS: hygiene-grooming, and dining-eating.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on observation, interview, and document review, the facility failed to ensure resident's care plan was implemented appropriately during transfers for 1 of 2 residents (R2) reviewed. Findings include: R2's admission Minimal Data Set (MDS) dated [DATE], indicated R2 had diagnoses of cerebral infarction (stroke) and anxiety disorder. R2's care plan dated 10/4/24, indicated R2 had an alteration in mobility related to ischemic stroke and directed staff to follow physical therapy instructions, and assist R2 with ambulation and transfers. R2 required assist of one staff, with front wheeled walker (FWW), and a gait belt. Further, R2 was identified to be at risk for falls related to ischemic stroke and psychotropic medication use and directed staff to follow physical therapy and occupational therapy instructions for mobility function. Facility document untitled and undated, however floor staff referred to the document as the care guide sheet, indicated R3 required assist of one staff for transfers and staff to follow behind R3 with wheelchair while ambulating. The document lacked evidence of R3 requiring the use of a gait belt for transfers. During an observation on 11/5/24 at 12:29 p.m., nursing assistant (NA)-A was observed to assist R2 with transferring from her wheelchair to the toilet. NA-A assisted R2 into the bathroom and directed R2 to grab the handrail and stand up from her wheelchair. R2 stood up and pivoted from wheelchair and sat onto toilet. NA-A then directed R2 to again grab the handrail and stand up from the toilet to perform toileting hygiene cares and NA-A assisted R2 with pulling up her incontinent brief and pants, and R2 pivoted and sat back down in her wheelchair. NA-A did not utilize a gait belt for either transfer. Further, NA-A assisted R2 in her wheelchair out of the bathroom and next to the bed and directed R2 to grab the handrail on the bed to stand up. When questioned about utilizing a gait belt at that time, NA-A stated, she won't wait, probably should use a gait belt, I don't know and continued to transfer R2. R2 pivoted and sat on the edge of her bed and NA-A assisted R2 to lay down in bed and then exited R2's room. During an interview on 11/5/24 at 1:46 p.m., NA-A stated R2 thought she was more independent than she was and had a history of falls in previous living setting. NA-A stated R2 would often self-transfer to the bathroom without notifying staff. Further, NA-A stated R2 required assist of one staff and she was a stand pivot transfer. NA-A stated R2 required staff to utilize a gait belt for transfers however, R2 did not have a gait belt available in her room or a pouch on her wheelchair for staff to utilize. In addition, NA-A stated staff were expected to utilize the care guide sheets or the resident's care plan accessible on staff's tablet at the nursing station to reference each resident's transfer status. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/5/24 at 4:21 p.m., NA-B stated she was not familiar with R2's care needs however, staff were expected to refer to the care guide sheet that was at the nursing station. The care sheet was a printout staff were expected to keep in their pockets however, NA-B did not have one in her pocket. During an interview on 11/5/24 at 6:34 p.m., NA-C stated R2 required limited assistance with transfers and did not require the use of a gait belt. NA-C stated staff were expected to utilize the care guide sheets as a reference on what each resident's care needs were including transfer status. During an interview on 11/6/24 at 8:18 a.m. licensed practical nurse (LPN)-A stated R2 required assist of one staff contact guard assist with ambulation and transfers with her walker. LPN-A stated staff utilized a gait belt if one was ordered however, R2 did not require a gait belt. During an interview on 11/6/24 at 8:53 a.m., interim director of nursing (DON) stated she was not familiar with R2's care and referred to the care plan which identified R2 required assist of one with a gait belt for transfers. Further, DON stated each resident who required a gait belt would have their own kept either in their room or in a pouch on their wheelchair. During an interview on 11/6/24 at 9:33 a.m., director of therapy stated R2 was a pivot transfer with her four wheeled walker (4WW) and staff should be utilizing a gait belt during the transfers for safety. Review of facility policy titled Care Planning revised 1/6/22, indicated the care plan should be used in developing the resident's daily care routines and would be utilized by staff personnel for the purposes of providing care or services to the resident.