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	09/11/2025

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 0656 Level of Harm - 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. (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

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	09/11/2025

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 0656 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure person centered fall interventions were care planned and implemented for 1 of 3 residents (R1) who were at risk for falls, which resulted in actual harm when R1 sustained a rib fracture as a result of a fall out of bed. The deficient practice was corrected prior to the start of survey, therefore was issued at past noncompliance.Findings include:R1's quarterly Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included metabolic encephalopathy (a change in how your brain works due to an underlying condition, can cause confusion or memory loss), neurocognitive disorder with Lewy bodies (a progressive brain disorder), anxiety disorder, and severe cognitive impairment. Further, MDS revealed R1 had one fall without injuries since prior assessment. R1's care plan dated 5/23/25, indicated R1 was a fall risk due to history of falls, impaired gait and mobility, neurocognitive disorder with Lewy bodies, chronic heart failure, metabolic encephalopathy, and moderate protein calorie malnutrition. R1's care plan directed staff to check toileting needs every 2-3 hours initiated on 8/28/25, monitor and report when resident attempts to self-transfer from wheelchair initiated 7/22/25, floor mat next to bed initiated 8/28/25, sign in room reminding resident of need for assistance initiated 8/28/25, and soft touch call light placed under the sheets and under hip while in bed initiated on 8/29/25.R1's Incident Review and Analysis dated 6/26/25, indicated on 6/19/25 at 5:45 a.m., R1 was found on the floor. R1 was found sitting facing the door with legs straight and was on their roommate's mat with back against roommate's bed. Further, document identified new intervention following the fall was a floor mat to bedside was placed and the intervention was care planned.R1's Incident Review and Analysis dated 9/5/25, indicated R1 had a fall on 8/24/25, at 8:30 a.m., R1 was found sitting on the floor by his bedside with his back leaning on his bed, there were no injuries at the time of the fall. Further, document identified new intervention following the fall was a soft touch call light placed under hip while in bed.R1's Incident Review and Analysis dated 9/5/25, indicated R1 had a fall on 8/28/25, at 8:05 p.m. R1 had an incontinent episode and the brief was wet, R1 pulled apart his wet brief indicating his discomfort and toileting needs. R1 put on his call light to alert staff he slid out of bed. R1 was sitting on floor with back against the bed. R1 denied pain and discomfort. Further, document identified R1's care plan was not followed as there was not a floor mat next to R1's bed or in his room.R1's After Visit Summary from the Emergency Department (ED) dated 8/28/25, indicated reason for visit was a fall and diagnoses included fall, closed fracture of one rib of left side and contusion of left shoulder. ED summary indicated chest x-ray did not show any rib fractures or pneumothorax, but computed tomography (CT) scan of the chest was suggestive of acute left lateral 9th rib fracture.R1's progress notes revealed the following:-On 8/28/25, R1 put on his call light to inform staff that he was sitting on the floor. R1 had no injuries and vital signs were stable. Staff will send per family request to the ED as fall was unwitnessed.-On 8/29/25, R1 had complained of increased left shoulder pain and back pain. Pain was noted when transferring or using the left arm.-On 9/2/25, R1's family spoke with staff regarding concerns with resident's pain management. Family indicated they thought this weekend R1 was in more pain and needed different medications. Writer reviewed R1's chart with family and confirmed staff was assessing pain but R1 had not reported pain or discomfort.R1's Pain Level Summary revealed R1 had rated his pain a 9/10 on 8/29/25, at 9:00 a.m. On 9/10/25 at 3:56 p.m., nursing aid (NA)-A stated R1 had impaired cognition and required assistance with all activities of daily living (ADL) including transfers with a mechanical stand lift. NA-A stated R1 exhibited behaviors such as wandering and self-transferring. Further, NA-A stated R1 was identified as a high fall risk and staff had been instructed to keep R1's bed low, fall mat next to bed, and touch pad call light while R1 was in bed. NA-A stated she was assigned to care for R1 on 8/28/25, and at approximately 8:00 p.m. R1 put his call light on. NA-A entered R1's room and observed R1 sitting on the floor and ripping apart his brief. NA-A stated at the time of the fall, R1's care plan did not identify R1 required a floor mat, but NA-A stated he required a low bed. NA-A stated R1 did not appear to be in pain and R1 was assisted back into bed after being assessed by the nurse. In addition, following R1's incident education was provided to staff regarding care plan interventions and new interventions of floor mat, and touch pad call light were added to R1's care plan.On 9/10/25 at 4:47 p.m., NA-B stated if a resident was at risk for falls and had interventions this would be identified on the staff's care sheets which was updated by the director of nursing (DON). NA-B stated education was provided to the staff regarding care plan interventions and referring the care sheets if staff are unsure.On 9/10/25 at 5:10 p.m., R1 was not observed in his room, however his bed