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	05/04/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain and ensure accurate administration of medications for 3 of 4 residents (R1, R3, R4) reviewed for medications. Findings includeR1's diagnoses list dated 4/29/26 included traumatic subdural hemorrhage (blood collection on the brain), disorder of urea cycle metabolism (liver disfunction which leads to build-up of ammonia in the blood), hepatic encephalopathy (decline in mental function caused by severe liver disease), unspecified convulsions, alcoholic cirrhosis of liver with ascites and hypothyroidism (underactive thyroid).R1's admission Minimum Data Set (MDS) dated [DATE] indicated no cognitive impairment.R1's provider order dated 4/3/26 instructed rifaximin (medication used to reduce risk of hepatic encephalopathy) 550 milligrams (mg), give one tablet by mouth two times daily for hepatic encephalopathy.R1's medication administration record (MAR) for April 2026 identified R1 did not receive nine doses of rifaximin from 4/3/36 through 4/7/26 as indicated by a 9 which instructed see nurse note.R1's nursing notes from 4/3/26 through 4/7/26 indicated a medication not available, on order, not available, arriving tonight, and unavailable, on order but the specific medication was not named.R1's nursing note dated 4/7/26 indicated pharmacy was contacted regarding resident's Rifaximin 550mg tablet that had not been delivered yet. Pharmacist stated the medication was on tonight's first delivery.R1's provider order dated 4/4/26 through 4/13/26 instructed Levothyroxine Sodium (synthetic thyroid hormone used to treat hypothyroidism) oral tablet 125 micrograms (mcg). Give one tablet by mouth in the morning related to hypothyroidism. Scheduled administration time was 6:00 a.m.R1's MAR for April 2026 identified R1 should have received 10 doses of Levothyroxine. R1 received Levothyroxine 125mcg on 4/4/26, 4/6/26, 4/7/26 and 4/8/26 as indicated by a checkmark with initials of the staff member administering the medication. The boxes were blank on 4/5/26, 4/9/26, 4/10/26, 4/11/26, 4/12/26, and 4/13/26.R1's medical record dated 4/4/26 through 4/13/26 did not identify if levothyroxine was administered on 4/5/26, 4/9/26, 4/10/26, 4/11/26, 4/12/26, or 4/13/26. R1's nursing note dated 4/13/26 at 1:25 p.m., indicated per medical doctor (MD), thyroid stimulating hormone poorly controlled. MD ordered Levothyroxine 125mcg to be discontinued and changed to 150mcg. R3's diagnoses list dated 5/1/26 included Parkinson's Disease, dyspnea (shortness of breath), and chronic sinusitis.R3's annual MDS dated [DATE] indicated no cognitive impairment.R3's provider order dated 8/5/25 instructed Advair Diskus (medication used to prevent shortness of breath and wheezing) 100-50 mcg per dose. 1 inhalation every 12 hours related to chronic sinusitis.R3's care plan dated 2/11/26 included alteration in respiratory status related to shortness of breath with an intervention of administer medications as ordered and monitor for side effectsR3's MAR for April 2026 identified R3 did not receive Advair on 4/23/26, 4/24/26, 4/25/26, 4/26/26 4/28/26 and 4/29/26 as indicated by a 9 which instructed see nurse note.R3's nursing note dated 4/23/26 at 7:00 a.m. indicated Advair Diskus was not available.R3's nursing note dated 4/24/26 at 8:10 a.m. indicated Advair Diskus was medication on order.R3's nursing note dated 4/27/26 at 7:09 a.m. indicated Advair Diskus was not available.R3's nursing note dated 4/27/26 at 8:35 p.m. indicated Advair Diskus will arrive on first run tomorrow per pharmacy.R3's nursing note dated 4/29/26 at 7:33 (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m. indicated Advair Diskus was med on order.R3's care plan dated 2/11/26 included alteration in respiratory status related to shortness of breath with an intervention of administer medications as ordered and monitor for side effectsDuring an interview on 4/29/2026 at 10:00 a.m., R3 stated he had not been receiving his inhaler recently. R4's diagnoses list dated 5/1/26 included type 2 diabetes mellitus, respiratory disorder, and hypothyroidism.R4's quarterly MDS dated [DATE] indicated moderately impaired cognition.R4's provider order dated 10/4/25 instructed Levothyroxine Sodium oral tablet 50mcg. Give one tablet by mouth in the morning related to hypothyroidism. Scheduled administration time was 6:00 a.m.R4's MAR for April 2026 identified R4 should have received 31 doses of Levothyroxine. R4 received 15 doses as indicated by a checkmark with initials of the staff member administering the medication. The boxes were blank on 4/1/26, 4/2/26, 4/3/26, 4/5/26, 4/9/26, 4/10/26, 4/11/26, 4/12/26, 4/13/26, 4/15/26, 4/16/26, 4/17/26, 4/23/26, 4/24/26, 4/25/26, 4/26/26, 4/27/26, 4/28/26, and 4/29/26.R4's medical record dated 4/1/26 through 4/29/26 did not identify if levothyroxine was administered on 4/1/26, 4/2/26, 4/3/26, 4/5/26, 4/9/26, 4/10/26, 4/11/26, 4/12/26, 4/13/26, 4/15/26, 4/16/26, 4/17/26, 4/23/26, 4/24/26, 4/25/26, 4/26/26, 4/27/26, 4/28/26, and 4/29/26. During an interview on 4/29/2026 at 12:40 p.m., trained medication assistant (TMA)-A stated when a medication was unavailable, she would first check to see if the medication had been reordered. If it had been ordered, TMA-A would let the nurse know so the pharmacy could be contacted.During an interview on 4/30/2026 at 10:24 a.m., licensed practical nurse (LPN)-A stated if a medication was unavailable for administration, she would check the emergency medication dispensing machine. If the medication was not available, LPN-A would call the pharmacy to see when it would be delivered. If the resident was going to miss a dose of medication, the provider should be notified. LPN-A stated a medication scheduled for 6:00 a.m. would alert for the night shift nurse. If the medication was not administered, the day shift nurse would not receive a notification.During an interview on 5/1/2026 at 8:11a.m., registered nurse (RN)-B stated the 6:00 a.m. medications pop up with the AM range medications which were yellow indicating the need to be administered. RN-B did not administer the 6:00 a.m. or the AM range medications unless the resident had specifically requested early medication administration. RN-B stated she was unaware R1 and R4's levothyroxine administrations only alerted on the night shift and did not flow to day shift. No one had alerted RN-B of the missing medication administrations. During an interview on 4/30/2026 at 1:27 p.m., director of nursing (DON) stated a blank box on the MAR indicated nothing was documented and the medication was not administered. DON was not aware R1's and R4's levothyroxine were not being administered. Not administering a medication was considered a medication error and DON should be notified right away. If a medication could not be located in the medication cart, the TMA should notify the nurse and together they would check the other medication cart and the medication rooms. If the medication cannot be located, the nurse should call the pharmacy to see when the medication will be delivered and check the medication dispensing machine to see if the correct medication and dose are available. If a dose will be missed, the resident's provider should be updated. During an interview on 4/30/2026 at 12:52 p.m., MD stated the facility should contact the provider when a resident misses a dose of medication. Persistently missed doses of Levothyroxine could lead to fatigue, heart rate changes, weight gain and dry skin. Suddenly receiving scheduled doses could lead to an amped up feeling with elevated heart rate, diarrhea, and a general warm feeling. Missed doses of Advair could lead to increased inflammation, and shortness of breath. The facility had not notified R1's or R4's provider about the missing doses of levothyroxine nor R3's provider for the Advair.During an interview on 5/1/2026 at 9:33 a.m., consultant pharmacist (CPh) stated consistency is important when administering levothyroxine. To achieve the full therapeutic effect, the medication must be administered at approximately the same time each day. A resident receiving levothyroxine would need periodic laboratory blood work. A provider reviewing the results would assume the resident had been receiving the medication as prescribed and may update the medication order based on the lab work which may result in the resident receiving more medication than was actually needed. Medication (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should always be offered to a resident unless there is a provider order stating otherwise. All resident refusals of medication or if a medication was held based on a provider order should be documented.The Medication Administration policy reviewed 4/24/26 instructed medications are administered as prescribed in accordance with food nursing principles and practices and only by persons legally authorized to do so. Five rights -right residents, right drug, right dose, right route and right time are applied for each medication administered. If a dose of regularly scheduled medication is withheld refused, not available, or given at a time other than the scheduled time, documentation of the unadministered dose is done as instructed by the procedures of use of the MAR system. If [XX consecutive doses] of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response.

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents were free from a significant medication error for 1 of 3 residents (R1) reviewed for medication errors. The facility's failure to ensure accurate transcriptions and available medication resulted in Immediate Jeopardy for R1 who was administered 39 incorrect and insufficient doses of lactulose (a medication that reduces ammonia levels in the blood) resulting in new onset of seizures, severe hyperammonemia and hospitalization.The IJ began on 4/3/26 when R1 did not receive six doses of scheduled lactulose because the medication was not available. The facility failed to ensure the lactulose order was accurately transcribed into R1's medical record resulting in 39 insufficient doses which subsequently resulted in R1's hospitalization. The administrator and director of nursing (DON) were notified of the IJ on 4/30/2026 at 4:45 p.m. The immediacy was removed on 5/1/26 but noncompliance remained at the lower scope and severity level of D - isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.Findings include:R1's diagnoses list dated 4/29/26 included traumatic subdural hemorrhage (blood collection on the brain), disorder of urea cycle metabolism (liver dysfunction which leads to build-up of ammonia in the blood), hepatic encephalopathy (decline in mental function caused by severe liver disease), unspecified convulsions (added 4/24/26), and alcoholic cirrhosis of liver with ascites. R1's admission Minimum Data Set (MDS) dated [DATE] indicated no cognitive impairment. R1's hospital discharge orders dated 4/3/26 instructed l2actulose oral solution 30 grams (g)/45milliliters (mL). Give 45mL four times daily for unspecified cirrhosis of the liver. Hold if greater than three stools per day. R1's transcribed electronic medical record (EMR) physician order for lactulose dated 4/3/26 was inconsistent with the hospital discharge order; instead of 30g/45ml the order directed to give R1 lactulose oral solution 10g/15mL; give 15mL four times daily for unspecified cirrhosis of the liver. Hold if greater than three stools per day.R1's medication administration record (MAR) for April 2026 identified R1 did not receive two doses of lactulose on 4/3/26 and four doses on 4/4/26 as indicated by a 9 which instructed see nurse note. R1 received 39 doses of 10g/15mL from 4/5/26 to 4/14/26.R1's nursing note dated 4/3/26 at 6:28 p.m., indicated lactulose was not on hand but would be delivered on the first or second run. R1's nursing note dated 4/14/26 at 11:42 p.m. indicated at approximately 9:50 p.m., R1 began experiencing seizure-like activity. R1 was ultimately sent to the hospital. R1's hospital Discharge summary dated [DATE] indicated R1 had been admitted due to hepatic encephalopathy, severe hyperammonemia (dangerously elevated ammonia levels in the blood that can cause confusion, altered mental status, and seizures) and new onset seizures.R1's nursing home provider note dated 4/27/26 indicated R1 had been hospitalized from [DATE] through 4/24/26 for encephalopathy and new onset seizure. It was discovered R1 was not taking lactulose correctly. Severe hyperammonemia was treated and resolved at time of discharge from the hospital. During an interview on 4/30/26 at 11:52 a.m., registered nurse (RN)-A stated she entered R1's admission orders into the EMR on 4/3/26. The concentration of 30g per 45mL of lactulose was not a drop-down option to be entered into the EMR, so she reached out to the pharmacy. RN-A thought the pharmacist told her 10g per 15mL was an equivalent dose to 30g per 45mL. RN-A sent an email to director of nursing (DON) asking to clarify the order with the provider.During an interview on 4/29/26 at 12:40 p.m., trained medication assistant (TMA)-A stated she noticed R1's lactulose order in the MAR did not match the order on the bottle. TMA-A stated the order on the bottle was to administer 45mL while the physician order was administer 15mL. She asked the nurse licensed practical nurse LPN-A; LPN-A directed TMA-A to administer the amount directed on the physician order which was 15 ml. During an interview on 4/30/26 at 10:24 a.m., LPN-A stated she noticed R1's lactulose order in the MAR did not match the order on the bottle. In that situation, LPN-A stated the information in the MAR was usually the correct order and administered 15mL of lactulose. If the MAR didn't match the medication container, the nurse (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was to call the pharmacy so a different label could be placed on the container, but sometimes an order would change and the medication supply on hand would be used without changing the label. LPN-A did not contact the pharmacy nor did she alert DON.During an interview on 4/30/26 at 1:27 p.m., the DON stated on 4/3/26, she received an email from RN-A requesting clarification of R1's lactulose order. A request for clarification was sent to R1's discharging provider, the same order was received, and no additional clarification was requested. DON was not aware the dosage amount on the medication bottle did not match what was in the MAR. Following R1's admission to the hospital on 4/14/26, R1's guardian requested information about R1's lactulose order. DON discovered R1 had been receiving 10g of lactulose four times a day instead of the ordered 30g of lactulose four times a day. DON contacted the pharmacy and R1's current provider to clarify the order. R1's lactulose order was changed in the MAR to reflect the correct order and staff who administered the incorrect dose received education on what to do if the MAR and medication container did not match. DON stated when staff discovered the order in the MAR and the order on the lactulose bottle did not match, the lactulose should not have been administered, and a nurse should have contacted the DON and/or the pharmacy for clarification of the correct dose. DON confirmed she had not been notified that the order in the MAR did not match the order on the lactulose bottle.During an interview on 4/29/26 at 1:49 p.m., pharmacist (Pharm D) stated lactulose was used for hepatic encephalopathy. Administering a lower dose than prescribed could lead to a build-up of ammonia in the body which could result in confusion, disorientation, and possibly seizures due to increased stress on the body. Pharm D confirmed R1's provider order printed on the bottle of lactulose sent to the facility on 4/3/26 was lactulose10g/15mL, Give 45mL by mouth four times daily. PharmD further stated administering 10 grams of lactulose instead of 30 grams over several days would be considered a significant medication error due to build up of ammonia in the body which could result in confusion, disorientation, and possibly seizures due to increased stress on the body.During an interview on 4/30/26 at 12:52 p.m., the medical director (MD) stated if there were any concerns about a provider order, the provider should be contacted right away for clarification. MD stated this was a significant medication error because administering a lower than prescribed dose of lactulose could lead to a build-up of ammonia and other toxins in the body which could lead to seizures and hospitalization.The Medication Administration policy last reviewed 4/24/26 instructed prior to medication administration right resident, right drug, right route and right time were to be applied for each medication being administered. Prior to administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label. If the label and MAR are different and the container has not already been flagged, indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room are searched. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the emergency kit. The IJ that began on 4/3/26 was removed on 5/1/26 when the following was verified by interview or document review:-Facility audited all lactulose and liquid medications for transcription accuracy.-All current resident medications reviewed to ensure medications are available and administered per order. -Policies and procedures related to transcription of physician orders, medication administration, reporting discrepancies, and medication not available to administer were reviewed.-All nurses, TMA's and health information were educated prior to the start of their shift on transcription of physician orders, medication administration including rights of medication administration, reporting discrepancies, and the process to address unavailable medications