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	04/25/2024

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

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 45842 Based on observation, interview, and document review, the facility failed to perform a self-administration of medication assessment and obtain provider orders to have medication left in room for 1 of 1 (R20) resident reviewed for self-administration of medication. Findings include: R20's care plan dated 12/12/21, indicated R20 had an alteration in cognition with a diagnosis of mild cognitive impairment. During an observation on 4/22/24 at 7:12 p.m., on R20's bedside table included a medication cup with four pills in it. No staff were in the room. During an interview on 4/22/24 at 7:17 p.m., trained medication aide (TMA)-A confirmed the medications had been given to R20 and left in his room for him to take later. TMA-A stated she does that sometimes because he does like to take them later then I give them to him. TMA-A was not sure if R20 had a self-administration of medication (SAM) form filled out. During an interview on 4/24/24 at 11:40 a.m., licensed practical nurse (LPN)-A stated that prior to being able to leave medications at bedside R20 needed to have a SAM form filled out and a provider order saying it was ok to self-administer medications. During an interview on 4/25/24 at 11:59 a.m., the director of nursing (DON) confirmed R20 did not have a SAM form completed and there were no orders to self-administer medications. She expected all staff would verify a SAM form and a provider order were in place prior to leaving medications at bedside for residents to self-administer. Facility policy, Self-Administration of Medications last revised 2/2024, indicated a SAM assessment would be performed prior to self-administration of medications to verify it was appropriate for the resident to self-administer medications. After verification, orders from the provider would be received.

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation, interview and document review the facility failed to provide privacy during personal cares for 1 of 3 residents (R13) observed during personal cares. Findings include: R13's quarterly Minimum Data Set (MDS) dated [DATE], indicated R13 had diagnoses which included Alzheimer's disease, dementia, depression, muscle weakness, and benign prostatic hyperplasia with lower urinary tract symptoms (age-associated prostate gland enlargement that can cause urination difficulty). In addition, R13's MDS identified he was moderately cognitively intact, was always incontinent of bladder and frequently incontinent of bowel and was dependent on staff for assistance with activities of daily living. During continuous observation on 4/24/24, the following was observed: -at 8:36 a.m., nursing assistant (NA)-A entered R13's room after donning gown and gloves. The room had a large window about three feet from the floor and approximately five feet in height and approximately six feet wide. The curtain was open, and the window faced the parking lot. The privacy curtain was pulled part way closed but did not prevent anyone opening the door from seeing the bed. NA-A told R13 what he was planning to do. NA-A took out disposable wipes and loosened R13's brief and cleaned the front of the peri-area and then assisted R13 to roll to the right side (R13' back faced the door). NA-A removed the brief and with new wipes cleansed R13's buttocks and placed a new pad and brief under R13. -at 8:42 a.m. NA-A wearing the same gloves pressed the call light for assistance from the nurse. While NA-A was waiting for the nurse he had R13 roll to his left side and positioned the pad and the brief. Wearing the same gloves NA-A left R13's gown up and his covers down around his feet leaving his genital area exposed while NA-A emptied the catheter bag. The curtain to the outside and facing the parking lot remained open during cares. The privacy curtain to the door was only pulled partway and did not prevent anyone entering the room from seeing R13 lying in bed. -at 8:59 a.m., NA-A placed covers on R13, lowered the bed, and left the room. During an interview on 4/24/24 at 9:02 a.m., NA-A verified he did pull the privacy curtain to the room door and hallway and did not close the curtain to the outside parking lot. During an interview on 4/24/24 at 9:09 a.m., licensed practical nurse (LPN)-A verified the curtain to the outside parking lot and the privacy curtain were not closed prior to care being performed. LPN-A verified staff should do this for resident privacy prior to starting cares. During an interview on 4/25/24 at 11:16 a.m., the director of nursing (DON) verified she would expect staff to pull the privacy curtain to the hallway and door and the curtain to the outside prior to performing cares to maintain dignity and privacy for residents. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Combined Federal and State [NAME] of Rights for Residents in Medicare/Medicaid Certified Skilled Nursing Facilities or Nursing Facilities dated 6/18/19, identified residents had the right to personal privacy which included room accommodations and personal care.

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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** 42587 Based on interview and document review, the facility failed to ensure ordered laboratory tests were completed and ordered orthostatic blood pressures (measurements of blood pressures from lying to sitting to standing reviewed looking for a drop in blood pressure with position changes) were completed as ordered for 1 of 1 resident (R13) reviewed for unnecessary medications. Findings include: R13's quarterly Minimum Data Set (MDS) dated [DATE], indicated R13 had diagnoses which included Alzheimer's disease, dementia, depression, muscle weakness, anemia, hypertension, normal pressure hydrocephalus (an abnormal buildup of cerebrospinal fluid in the brain's ventricles [cavities]) and presence of a cerebrospinal fluid drainage device. In addition, R13's MDS identified he was moderately cognitively intact, was taking antipsychotics, anticoagulants, and opioids, and was dependent on staff for assistance with activities of daily living. R13's MDS identified he had no behaviors or rejections of care. R13's care plan initiated 9/20/18, and revised 6/9/23, identified R13 had an alteration in hematological status related to use of Xarelto (used to treat and prevent blood clots) due to a history of pulmonary embolisms. Interventions included to give medications as ordered, to monitor for side effects and effectiveness. In addition, to monitor, document, report as needed signs and symptoms of anemia, which included low hemoglobin and hematocrit (the hematocrit measures the volume of red blood cells compared to the total blood volume). R13's care plan dated 9/20/18, identified R13 used antipsychotic medication, interventions included to monitor for adverse effects every shift and to have the consultant pharmacist review medications monthly. R13's Order Summary Report identified the following: -2/11/21, CBC (complete blood count, blood test used to look at overall health and find a wide range of conditions including anemia) every three months starting on the first for one day routine lab every three months on Monday lab day. -6/14/23, monitor orthostatic blood pressure monthly while resident is receiving antipsychotic medications one time a day every one month(s) starting on the 16th. A review of R13's laboratory results identified the following: -4/23/23 valproic acid (blood test to check levels of valproic acid) -8/28/23, BMP (blood test basic metabolic panel), lymphs, monocytes, eosinophils, basophils (blood differential test associated with immune response and inflammation) -12/21/23, BMP (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A request for CBC laboratory tests completed over the past year was requested but not provided. A review of R13's Weights and Vitals Summary from 2/7/24 through 4/24/24, identified R13 had measurements for lying blood pressure recorded, none for sitting or standing. A review of R13's progress notes dated 2/25/24 through 4/25/24, did not identify R13 as refusing cares or tests. During an interview on 4/25/24 at 10:59 a.m., the director of nursing (DON) reviewed R13's electronic medical record (EMR). The DON verified R13's order for CBC was not being followed and concerns would be a low hemoglobin would not be identified or treated. The DON verified the orthostatic blood pressures were not being measured as ordered, as well. The DON stated it is difficult to complete orthostatic blood pressures for some residents, but she would expect nursing staff to contact the provider if they were not able to complete orders as written. During an interview on 4/26/24 at 3:02 p.m., the consultant pharmacist (CP) stated she would expect staff to follow provider orders for CBC related to anemia and orthostatic blood pressures when a resident is taking an antipsychotic. CP stated she would expect staff to contact the provider if they were not able to carry out the orders as written. Medication and Treatment Orders dated 2/2024, did not address what staff should do when they were unable to carry out an order. Psychotropic Medication Use undated, identified with initiation of an antipsychotic medication, residents who do not require use of a mechanical full-body lift will have an orthostatic blood pressure performed on a monthly basis, unless otherwise indicated by provider.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42587 Based on observation, interview, and document review the facility failed to ensure the hot water was at safe temperatures. This failed practiced placed 24 residents who were independent with their mobility at risk for potential burns. Findings include: On 4/23/24 at 9:16 a.m., during a resident screening the water temperature in R8's bathroom felt very hot to the touch after running the hot water for only a few minutes. Licensed practical nurse (LPN)-A checked the temperature as well and verified the temperature from the faucet felt too hot and said she would fill out a maintenance slip to have the temperature checked. On 4/23/24 at 12:34 p.m., the sink in the east kitchenette was used and the water felt very hot after running the hot water briefly. On 4/23/24 at 1:04 p.m., maintenance director (MD)-A stated he was checking water temperatures in resident rooms and all over the building weekly. MD-A stated he had not had any complaints regarding water temperatures and stated he was trying to keep the hot water between 114 - 116 degrees Fahrenheit (F). MD-A brought a thermometer and measured temperatures, they were as follows: -room [ROOM NUMBER] bathroom sink 125 degrees F. MD-A verified this was too hot. -West kitchenette sink 130 degrees F. At this point MD-A verified the water was too hot and left to check the hot water heaters. The facility provided water temperature log dated 3/15/24, indentified a water temperature of 121 degrees F in room [ROOM NUMBER]. The logs did not show any corrective actions taken. On 4/23/24 at 2:24 p.m. the administrator stated they wanted to keep the hot water temperatures at 120 degrees F or below based on what he had been told by maintenance. The administrator verified residents could be burned by water that was too hot. On 4/25/24 at 10:00 a.m., MD-A stated he thought the hot water was okay at 120 degrees F or lower but now stated safe hot water temperatures were supposed to be between 105 and 115 degrees F. On 4/25/24 at 10:25 a.m., MD-A verified the facility's hot water was running too hot. On 4/25/24 at 11:28 a.m., the administrator verified the facility water temperatures had been too high and the danger was potential burns to residents. The administrator stated he would expect staff to report hot water that seemed too hot to the touch. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A document titled TELS MASTERS no date, identified best practice was for facilities to test and log the hot water temperatures weekly. The document identified the water should run for three minutes before taking a reading and identified temperatures should fall between 105 to 115 degrees F. The document identified the purpose was to prevent accidental burns and scalds and to ensure any issues were addressed in a prompt and consistent manner. Water Temperatures, Safety of dated 12/2009, identified the following Tap water in the facility shall be kept within a temperature range to prevent scalding of residents. The policy further identified the following Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to state regulation. The policy directed staff to report to their immediate supervisor any time water temperatures felt excessive to the touch. Minnesota State Statute 4658.1415 Subp. 7 identified the following: Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to 115 degrees Fahrenheit at the fixtures.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49877 Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders for 2 of 4 residents (R11, R187) observed to receive medication. A total of 2 errors out of 32 opportunities were identified resulting in a facility error rate of 6.25 percent. Findings include: R11: R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11's diagnoses included gastro-esophageal reflux disease (a disease where stomach acid backs up into the tube connecting your mouth to stomach [esophagus]), abnormal weight loss, anxiety, and Crohn's disease (inflammation of the tissue lining the digestive tract). R11's MDS identified her as severely cognitively impaired. R11's Physician Order Report dated 4/25/24, identified R30's current physician-ordered medications and treatments. This included an order for omeprazole (a medication used to treat gastro-esophageal reflux disease by blocking gastric acid production) 20 milligrams (mg) capsules, give 2 capsules by mouth in the morning. The order had a listed start date of 12/2/23. During observation on 4/24/24 at 7:04 a.m., licensed practical nurse (LPN)-A prepared R11's morning medications using R11's electronic Medication Administration Record (MAR). LPN-A compared the MAR to each individual medication package label. After each medication was compared, oral medications were placed into a medication cup. During observation on 4/24/24 at 7:08 a.m., LPN-A placed 1 omeprazole capsule into R11's medications cup. On 4/24/24 at 7:12 a.m., LPN-A confirmed she had completed preparing R11's medications and was about to administer. When asked how many 20 mg omeprazole capsules were placed in R11's medication cup, LPN-A stated one and explained R11's omeprazole order had changed and R11 should be receiving 20 mg of omeprazole and not 40 mg. LPN-A confirmed R11's MAR and medication package both stated to give 2 capsules of 20 mg omeprazole in the morning which would equal 40 mg. The MAR and medication package gave no indication the order had changed. On 4/24/24 at 7:18 a.m., LPN-A administered 1 capsule of 20 mg omeprazole to R11. On 4/24/24 at 7:25 a.m., LPN-A stated she consulted with the director of nursing (DON) about R11's omeprazole order. The DON confirmed the information on R11's MAR and medication package was correct and R11 should be receiving 2 capsules of 20 mg omeprazole which equals 40 mg. R187: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R187's Diagnosis Report dated 4/25/24, identified R11's diagnoses included Parkinson disease (a brain disorder causing unintended or uncontrollable body movements), major depression, and hypertension (high blood pressure). R187's physician signed History and Physical dated 4/14/24, included the medication ropinirole (a medication used to reduce unintended or uncontrollable body movements) 0.5 mg tablet at noon and 5 p.m., and 1 mg at 7 a.m. Ropinirole order was verified on 4/14/24. During observation on 4/25/24 at 8:02 a.m., trained medication aid (TMA)-B prepared R187's morning medications using R187's electronic MAR. TMA-B compared the MAR to each individual medication package label. After each medication was compared, oral medications were placed into a medication cup. On 4/25/24 at 8:04 a.m., TMA-B placed 1 ropinirole 0.5 mg tablet into R187's medication cup. On 4/25/24 at 8:09 a.m., LPN-A confirmed she had completed preparing R187's medications and was about to administer. When asked how many 0.5 mg ropinirole tablets were placed in R187's medication cup, TMA-B stated one. TMA-B reviewed R187's MAR and ropinirole medication label and confirmed both directed to give 1 mg of ropinirole in the morning. When asked if giving 1 tablet of 0.5 mg ropinirole in the morning was the correct dose, TMA-B stated yes, I should give 1 (tablet) now and 1 (tablet) at noon. On 4/25/24 at 8:11 a.m., LPN-A administered 1 tablet of 0.5 mg ropinirole to R187. During interview on 4/25/24 at 8:14 a.m., the DON would expect medication's to be given as ordered. When asked to about R187's ropinirole order, DON reviewed the MAR and confirmed R187 should receive 2 tablets of 0.5 mg ropinirole in the morning and 1 tablet at noon and 5 p.m. DON confirmed giving 1 tablet of 0. 5 mg ropinirole in the morning was an error and she will take immediate corrective action. DON verified having a discussion with LPN-A regarding R11's omeprazole order and confirmed giving 1 tablet of 20 mg omeprazole was an error. Policy for administering medications was requested and not provided. Facility reported they do not have a policy specifically addressing how to administer medications.

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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** 42587 Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and glove use practices were maintained for 1 of 4 residents (R13) observed during personal cares. Findings include: R13's quarterly Minimum Data Set (MDS) dated [DATE], identified R13 had diagnoses of Alzheimer's disease, dementia, depression, muscle weakness, and benign prostatic hyperplasia with lower urinary tract symptoms (age-associated prostate gland enlargement that can cause urination difficulty). In addition, R13's MDS identified he was moderately cognitively intact, was always incontinent of bladder and frequently incontinent of bowel, and was dependent on staff for assistance with activities of daily living. During an observation on 4/24/24 at 8:36 a.m., nursing assistant (NA)-A entered R13's room after donning gown and gloves. NA-A told R13 what he was going to do, asked R13 if he had pain, removed his covers, removed the pillow behind his back, removed a package of disposable wipes from the bedside cupboard, opened R13's brief and cleaned R13's peri-area (front), then wearing the same gloves assisted R13 to roll to his right side. NA-A wearing the same glove removed R13's brief which had small amount of unformed brown stool and proceeded to wipe R13's buttocks removing stool, using disposable wipes. NA-A placed a new pad under R13. -at 8:42 a.m., NA-A wearing the same gloves pushed R13's call light, moved the bedside table, rested his hands on R13's grab bar, emptied R13's condom catheter drainage bag, cleaned the spigot of the foley bag with an alcohol wipe, and still wearing the same gloves put the disposable wipes in the bedside cupboard. -at 8:48 a.m., NA-A wearing the same pair of gloves, used his pinky of left gloved hand to push R13's call light. -at 8:59 a.m., NA-A wearing the same pair of gloves, placed the new brief, lowered R13's bed, opened and closed closet doors and drawers. NA-A wearing the same gloves moved R13's beverage cup off his breakfast tray, picked up the tray, set it down by the door, removed his gown and gloves in the room (no hand hygiene) took the tray to the tray cart and then went to the kitchenette sink and washed his hands with soap and water. During an interview on 4/24/24 at 9:02 a.m., NA-A verified he did not change his gloves after he performed peri-care for R13. NA-A verified he did not change his glove and wash his hands until he left R13's room. NA-A verified he touched several items in R13's room including the handle of R13's beverage cup and that this had the potential to spread infection. During an interview on 4/24/24 at 9:09 a.m., licensed practical nurse (LPN)-A stated staff were expected to change gloves after any peri-cares and perform hand hygiene between glove changes to prevent infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/25/24 at 11:16 a.m., the director of nursing (DON) stated she would expect staff to remove gloves and perform hand hygiene during peri-cares to prevent contamination of surfaces and to prevent infections. Hand washing policy dated 2/2024, identified staff should perform hand hygiene when conducting a procedure that required the use of gloves and they would follow proper hand washing before donning gloves and after removing gloves. The policy further directed staff to complete hand washing to prevent the spread of infection after changing incontinent products or cleaning up after someone who has used the toilet.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation and interview, the facility failed to provide a bathroom call light for 1 of 1 resident (R13) reviewed for call lights. Findings include: R13's quarterly Minimum Data Set (MDS) dated [DATE], indicated R13 had diagnoses which included Alzheimer's disease, dementia, depression, muscle weakness, and benign prostatic hyperplasia with lower urinary tract symptoms (age-associated prostate gland enlargement that can cause urination difficulty). In addition, R13's MDS identified he was moderately cognitively intact, was always incontinent of bladder and frequently incontinent of bowel and was dependent on staff for assistance with activities of daily living. During a resident screening on 4/22/24 at 7:24 p.m., an observation was made of R13's bathroom. R13's bathroom had no call light. On 4/24/24 at 11:59 a.m., nursing assistant (NA)-B verified the call light was missing in R13's bathroom. NA-B verified any resident who used R13's bathroom would have no means to call for help/assistance. On 4/25/24 at 10:20 a.m., maintenance director (MD)-A stated he would expect every resident bathroom to have a call light so they would be able to call for help/assistance. On 4/25/34 at 11:30 a.m., the administrator verified each resident bathroom should have a call light so they would have a way to call for help if in the bathroom.