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	06/05/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure Section N of the Minimum Data Set (MDS) was accurately coded for 1 of 3 residents (R7) reviewed for unnecessary medications. Findings include: R7's quarterly MDS dated [DATE], identified a diagnosis of diabetes mellitus. Section N, which covers medications received during the assessment period, identified R7 was given insulin injections two times during the look back period. R7's provider order, identified dulaglutide subcutaneous solution (a GLP-1 receptor agonist, which is not insulin) 0.5 milliliters (ml)/5 milligrams (mg) to be injected one time a week every Wednesday related to diabetes mellitus, and was not taking any inslun during the look back period During an interview on 6/4/25 at 12:56 p.m., licensed practical nurse (LPN)-A reviewed R7's medication list and confirmed R7 didn't take insulin. During an interview on 6/5/25 at 3:38 p.m., registered nurse (RN)-A, an MDS coordinator, stated section N was coded inaccurately for R7. RN-A stated accurately coding the MDS was important because it reflected the plan of care for the resident. A policy regarding MDS completion and accuracy was requested but not received.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 secure an oxygen tank in a resident room for 1 of 1 resident (R32) reviewed for accidents. Findings include: R32's quarterly Minimum Data Set (MDS) dated [DATE], identified R32 had diagnoses which included chronic obstructive pulmonary disease (COPD [a group of lung diseases that block airflow and make it difficult to breath]), depression and anxiety. In addition, R32 was cognitively intact and required substantial to maximum assistantance with activities of daily living. R32's undated Order Summary Report identified R32 had an order for oxygen two to four liters via nasal cannula. R32's care plan dated 2/13/25, identified R32 had an alteration in oxygen/gas exchange related to COPD. Interventions included to monitor oxygen saturations as ordered and as needed and to administer oxygen as ordered. During an observation on 6/2/25 at 1:58 p.m., R32 was seated in his wheel chair in his room wearing oxygen via nasal cannula at one liter. During an observation on 6/3/25 at 11:14 a.m., in R32's room an oxygen tank was observed free standing near a stationary oxygen holder that contained five other oxygen tanks. The maintenance director (M)-A was present and verified oxygen tanks should always be secured in a holder for safety. M-A stated the tank if knocked over could turn into a missile and go through walls. During and interview on 6/3/25 at 11:22 a.m., the associate administrator verified oxygen tanks should always be secured and not free standing for safety. During an interview on 6/5/25 at 10:21 a.m., licensed practical nurse (LPN) verified staff received oxygen train as part of hazard training. During an interview on 6/5/25 at 12:58 p.m., the director of nursing (DON) verified oxygen tanks should never be left free standing. The DON verified the danger was the oxygen tank could tip over and go through a wall. A policy on oxygen storage was requested but not provided.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure the water chamber of a bipap machine was emptied and dried between uses for 1 of 3 residents (R143) reviewed for respiratory care. Findings include: R143's admission MDS dated [DATE], identified intact cognition and diagnoses of acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), acute bronchospasms, and sleep apnea. R143's care plan dated 5/23/25 didn't address the care of oxygen and bipap equipment. R143's provider orders dated 5/21/25 identified the following: -Bipap machine on at nighttime, two liters oxygen while sleeping to keep saturations at or above 92 percent. -Change nebulizer tubing and mask weekly on Saturday -Change water on bipap daily. Empty and dry out chamber and fill bipap water chamber with distilled water to the fill line at bedtime. During an interview on 6/2/25 at 4:04 p.m., R143 stated she used her oxygen and bipap daily. The bipap machine is on the table next to her med, there is moisture visible in the water chamber, with the face mask attached to the hose and coiled on top of the dresser. During an observation on 6/3/25 at 10:10 a.m., R143 was not in her room. The bipap machine is on bedside table with water visible in the chamber. During an observation and interview on 6/5/25 at 12:51 p.m., R143's bipap machine is beside her bed with the water chamber partly full of water, the mask is attached to the tubing. R143 stated the staff filled the water chamber on the bipap machine for her, and so far no one had come to empty and rinse out the water chamber. During an interview on 6/5/25 at 1:05 p.m., LPN-A stated bipap and cpap machines should have the water emptied and chambers dried, and the face mask wiped down, every day. LPN-A added the filters were changed on Saturdays, and that R143 had been refusing her bipap at times. During an interview on 6/5/25 at 1:48 p.m., the DON stated she would expect the water chamber to be emptied and refilled daily, because it was important to help prevent possible infections. A policy was requested but not received.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to ensure food temperatures were monitored prior to and during meal service to prevent risk of food-borne illness. This had the potential to affect all 42 residents residing at the facility. Findings include: During observation on 6/3/25 at 8:40 a.m., residents were being served breakfast. Breakfast consisted of scrambled eggs, sausage, and cinnamon rolls. Eggs and sausage were in aluminum foil inside of crock pots on both units of the facility. Crock pots were set to the warm setting. Staff served residents individually and plated their requested food from the crock pots. Staff did not check the temperature of the food during the breakfast service. During observation on 6/4/25 at 7:12 a.m., residents were being served breakfast. Breakfast consisted of biscuits and gravy. Gravy was in the crock pots on east and west units of the facility. Crock pots set to the warm setting. During observation on 6/4/25 at 7:58 a.m., both crock pots were still on and set to warm setting. During observation on 6/4/25 at 8:31 a.m., both crock pots were still on and set to warm setting. During observation on 6/4/25 at 9:29 a.m., both crock pots were still on and set to warm setting. During observation on 6/4/25 at 10:15 a.m., both crock pots were still on and set to warm setting. During observation on 6/4/25 at 10:31 a.m., east unit crock pot was off and empty. [NAME] unit crock pot was on and set to warm setting. During interview on 6/4/25 at 11:36 a.m., dietary aide (DA)-A stated dietary staff were responsible for bringing out breakfast in the morning. DA-A further stated they did not check breakfast food temperatures and was unsure of who did. During interview on 6/4/25 at 11:45 a.m., corporate dietary manager (CDM) stated concerns with using crock pots for food service. CDM explained temperature control was difficult with the crock pots. CDM further stated temperature control was important to food service in order to prevent food-borne illness. During interview on 6/5/25 at 9:11 a.m., nursing assistant (NA)-A stated dietary staff bring out breakfast and put into crock pots. NA-A further stated they never had to temp breakfast. The breakfast temperature logs were requested but not provided. Per email with administrator on 6/5/25 at 10:23 a.m., Thank you for bringing the breakfast temps to our attention. We have food log temps, however it appears that breakfast was not a meal included with this. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility Food Preparation and Service policy revised April 2019, indicated proper hot and cold temperatures are maintained during food service.' Policy also instructed 'the temperatures of foods held in steam tables are monitored throughout the meal by food and nutrition services staff.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and document review, the facility failed to ensure staffing data was correctly submitted, for 1 of 4 quarters(quarter 3) reviewed, to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. Findings include: The Payroll Based Journal Report (PBJ) [NAME] Report 1705D for quarter 3 2024 (April 1 - June 30), identified the metric for failure to have licensed nursing coverage 24 hours per day and low weekend staffing were triggered. The PBJ report indicated the facility did not have licensed nursing coverage for the following dates: -4/27/24 -4/28/24 -5/11/24 -5/12/24 -5/18/24 -6/1/24 -6/22/24 -6/23/24 -6/29/24 Review of timecards from the listed dates showed the facility had licensed nursing staff coverage for 24 hours on each date. During joint interview on 6/5/25 at 12:44 p.m., administrator, associate administrator (AA), and corporate nurse (CN) stated being unaware of any problem with the submission of staffing data. Administrator, AA, and CN could not state why the PBJ report indicated a lack of licensed nursing coverage. AA stated the discrepancy might have been related to using agency staff, but did not actually know if that was the problem. A policy on PBJ was not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 ensure alcohol-based hand sanitizer was in use in the hand hygiene dispensers throughout the facility. In addition, the facility failed to ensure shared equipment was disinfected between residents for 1 of 2 residents (R9) observed to use a lift; failed to ensure staff completed appropriate hand hygiene and glove use for 2 of 4 residents (R1, R22) observed during cares; failed to ensure the overnight urine collection bag was cleaned prior to storage for 1 of 1 residents (R10) reviewed for catheter care. Findings include: Facility Hand Sanitizer During an observation on 6/3/25 at 3:40 p.m., the hand sanitizer in a free standing black eco lab stand felt like water and did not have an alcohol odor. A staff member opened the hand sanitizer compartment and the container was labeled as benzalkonium. The associate administrator and the director of nursing (DON) were present and both stated they were not aware the product was not an alcohol based product. The associate administrator went to see what kind of product was in resident rooms and confirmed it was the same eco lab product in the resident room with the benzalkonium product. This had the potential to affect all residents residing in the facility, as all resdient rooms had the eco lab product in the wall mounted dispensers. During an interview on 6/4/25 at 8:25 a.m., the nurse consultant (NC)-E verified the benzalkonium product was five to nine percent alcohol and hand sanitizer products needed to be at least 65% alcohol based. The label on the hand sanitizer product identified it as Ecolab DigiSan with the active ingredient as benzalkonium chloride 0.1%. The Centers for Disease Control (CDC) Handsanitizer guidelines and recommendations dated 3/12/24, identified the following: Hand Sanitizer Guidelines and Recommendations Key the following points: - Washing hands with soap and water is the best way to get rid of germs in most situations. - If soap and water are unavailable, use a hand sanitizer with at least 60% alcohol to clean your hands. - You can tell if the sanitizer contains at least 60% alcohol by checking the product label. The facility policy Hand Washing dated 2/2024, identified hands should be washed before eating food, and Alcohol-Based Hand Sanitizers (ABHS) - ABHS should not be used as a replacement for proper hand washing when hands are visibly soiled. If, however, hands are not visibly soiled, or soap and water are not available, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used to quickly reduce the number of germs on hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The undated Ecolab manufacurers indications for benzalkonium chloride 0.1%. identified that Food code-compliant hand sanitizer gel that reduces the level of bacteria on hands for use between soap and water hand washing. This formula is more than 99.5% effective in in-vitro testing against a broad range of foodborne illness-causing bacteria. and is appropriate for kitchen use. Equipment Disinfection R9's quarterly Minimum Data Set (MDS) dated [DATE], identified R9 had diagnoses which included heart failure, urinary retention, diabetes mellitus, , and dementia. In addition, R9 had moderate cognitive impairment and was dependent on staff for activities of daily living including bed to wheel chair transfers. During an observation on 6/3/25 at 2:21 p.m., NA-C was observed bringing R9 into her room, NA-C exited the room. A sign was posted on the outside door which identified the resident was on enhanced barrier precautions. On 6/3/25 at 2:26 p.m., NA-C brought a mechanical lift into R9's room, came out and put on an isolation gown and put on gloves and went back into the room closing the door. On 6/3/25 at 2:49 p.m., NA-C brought the mechanical lift out of R9's room and parked in against the wall. There were not any cleaning wipes in the pocket on the mechanical lift. On 6/3/25 at 2:56 p.m., NA-C stated nights cleans the mechanical lifts. NA-C stated she wiped the machine down after using it with the skin care wipes that were in the room. NA-C verified R9 was on enhanced barrier precautions. On 6/5/25 at 12:59 p.m., the DON stated she would expect staff to clean lift equipment after use, she verified it was not acceptable to disinfect the equipment with the personal care wipes used for resident cares. A policy on equipment disinfection was requested but not provided. Hand Hygeine, Glove Use R1 R1's quarterly MDS dated [DATE], identified R1 had diagnoses which included broken left hip prosthesis sequela, open left hip joint, morbid obesity, acquired absence of left hip joint, depression, anxiety, and schizophrenia. R1's had mild cognitive impairment, was dependent on staff for activities of daily living, had no rejections of care, and had a surgical wound. R1's care plan was requested but not provided. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/4/25 at 10:22 a.m., NA-D and NA-G put on isolation gowns and gloves and entered R1's room after knocking. NA-D and NA-G rolled R1 to his right side and NA-G cleaned stool from the buttocks using disposable wipes. NA-F then applied protective ointment to R1's buttocks, without removing the soiled gloves. R1 had more stool which was cleaned again by NA-G who then placed a new brief and pad and took the protective ointment tube and reapplied the ointment, without changing gloves or providing hand hygiene, R1 was rolled to his back. NA-D then took the protective ointment from NA-G and applied the ointment to R1's right hip. Both NA's removed their gloves, isolation gowns, performed hand hygiene with hand sanitizer and exited the room. During an interview on 6/4/25 at 10:43 a.m., NA-G verified they should have changed gloves and sanitize their hands after cleaning a resident who had a bowel movement. NA-G verified they did not do this during cares. During an interview on 6/5/25 at 12:59 p.m., the DON stated she would expect staff to change their gloves and wash their hands after cleaning a resident who'd had a bowel movement. R22: R22's annual MDS dated [DATE], identified R22 had severe cognitive impairment and diagnoses of dementia, palliative care, limitation of activities due to disability, and low back pain. R22 needed extensive assist with bed mobility, was non-ambulatory, dependent for transfers, frequently incontinent of bowel and occasionally incontinent of urine. R22's care plan was not provided. On 6/3/25 at 11:45 a.m., NA-D and NA-C were assisting R22 with incontinence, after removing her soiled brief and having her use the commode. Both NAs were wearing gloves. NA-C used a cloth to provide peri care, first to the front and then to the back. NA-D assisted to hold R22 on her right side while NA-C tucked a clean brief underneath R22 while wearing the same gloves she provided peri care with. Both NAs worked together to get R22's pants on, and the sling for the lift centered underneath her. NA-C positioned R22's wheelchair underneath her while NA-D operated the lift controls, and once seated both NAs removed the loops from the sling. NA-C picked up and moved the commode out of the way, opened the door to the hall, grabbed a hold of the sling lift, all while wearing the same gloves, and brought the lift out into hall. NA-C left the lift along the side of the hall, walked across the hall to the kitchenette, removed her gloves and threw them in a trash can, then turned and grabbed a coffee cup off a table and walked toward the dining room. During interview on 6/3/25, at 12:15 p.m. NA-C stated she would normally wash her hands after removing gloves, but it was lunch time, and she was in a hurry. NA-C stated she used hand sanitizer in the kitchenette after removing her gloves. NA-C then walked to a sink across from the nursing station, washed her hands with soap and water, and then stated there weren't very many hand sanitizers around here. It was noted there was no hand sanitizer in the kitchenette. During an interview on 6/3/25 at 1:53 p.m., NA-D stated she had infection prevention training through her agency, on the computer, and with showing how she used personal protective equipment (PPE). During an interview on 6/5/25 at 8:27 a.m., the DON stated she told her staff all the time, there were no gloves allowed in the hallway, and they need to clean their hands before and after gloving. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy Hand Washing dated 2/2024, identified proper hand washing techniques should be used to protect the spread of infection. The policy identified hand washing shall be completed after changing incontinent products or cleaning up after someone who has used the toilet. Catheter Care R10's quarterly MDS dated [DATE], identified moderately impaired cognition and diagnoses of benign prostatic hyperplasia and nocturia. R10 had a condom catheter (an external male catheter) and was always incontinent of urine. R10 needed maximum assist with toilet hygiene. R10's provider order dated 9/18/23, identified a condom catheter at resident bedtime, around 7:00 p.m., and it was ok to keep on during the day. R10's care plan dated 9/20/18, identified functional bladder incontinence with an intervention to use a condom catheter at night and during the day as needed, check for irritation or sores prior to application of new condom catheter. During an observation on 6/4/25 at 9:03 a.m., after putting on and gloves, NA-F removed the urine collection bag out of the blue privacy bag and pulled the tubing loose from the condom catheter, held the tube up so the remaining urine drained down into the collection bag. NA-F then opened the spout on the drainage bag, wiped the spout with an alcohol wipe and drained the urine into a graduate cylinder. Once the bag was empty, NA-F coiled up the tube and placed the collection bag and tube into the blue privacy bag and explained she would leave it in the bag, it was considered hidden if it was in that bag. During an interview on 6/4/25 at 11:55 a.m., LPN-A stated for R10, they need to rinse out the bag and tubing before placing it back into the privacy bag. LPN-A added the tubing gets changed on Saturday nights for everyone. During an interview on 6/5/25 at 8:27 a.m., the DON she would expect the catheter bag and tubing to be rinsed out before they were stored. A policy was requested but not received.