Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 3, 2025

Administrator
The Waterview Woods LLC
601 Grant Avenue
Eveleth, MN 55734

RE: CCN: 245277
Cycle Start Date: December 31, 2024

Dear Administrator:

On January 10, 2025, we notified you a remedy was imposed. On January 22, 2025 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 20, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 31, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 10, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 31, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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Electronically delivered
January 10, 2025

Administrator
The Waterview Woods LLC
601 Grant Avenue
Eveleth, MN 55734

RE: CCN: 245277
Cycle Start Date: December 31, 2024

Dear Administrator:

On December 31, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D),whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On December 23, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 - Free of Accident Hazards/Supervison/Devices was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 31, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 31, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 31, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Waterview Woods LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective December 31, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Alex Warren, Regional Operations Supervisor

Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 1, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

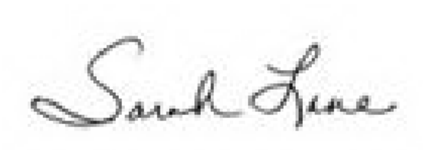
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	C 12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW WOODS LLC	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/30/24 to 12/31/24, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed H52773681C (MN00108492) and H52773563C MN00109320 a deficiency was issued at (F689) at PAST NON-COMPLIANCE and (F656). The IJ began on 12/22/24 at 8:10 p.m. when R1 was transferred with a ceiling lift using a reported toileting sling of unknown size, fell out of the sling, hit head on the ground, and sustained a laceration to the back of head. The administrator and director of nursing (DON) were informed of the IJ on 12/31/24 at 4:45 p.m. The facility implemented corrective action on 12/23/24. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000	Past noncompliance: no plan of correction required.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		1/20/25

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

Electronically Signed | 01/16/2025

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F 656	Continued From page 1 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a	F 656	F656 Develop/Implement Comprehensive Care Plan	

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F 656	Continued From page 2 comprehensive person-centered care plan based on the resident assessment which identified the type and size of sling required during transfers for 3 of 3 residents (R1, R3, R4) reviewed for mechanical lift use. Findings include: R1's fall incident report from 12/22/24 identified R1 was admitted to the facility on 6/11/24 with a primary diagnosis of chronic combined systolic and diastolic (congestive) heart failure (heart unable to pump enough blood to organs) and nonrheumatic aortic stenosis (narrowing of heart valve). R1's last brief interview for mental status (BIMS) was on 11/13/24 which showed moderate cognitive impairment. Incident report identified nursing assistant (NA)-A was transferring resident via ceiling lift from wheelchair to bed when R1 put her arms up which caused R1's upper body to slide through the sling. Licensed practical nurse (LPN)-B found R1 on the floor who was noted to have a bump that was bleeding on back of head. R1 was assessed by hospice nurse and did not require stitches. At the time of the fall, R1 was upgraded to a ceiling lift due to not standing in the stand aide and the correct sling and size were used during the transfer. Specific size and type of sling was not noted. Post fall, the director of nursing (DON) attempted education with the resident on proper body placement when in a sling. Staff was to now use a full body sling and will have 2 staff members presents during transfers. R1's progress note dated 12/22/24 at 8:37 p.m., identified resident upgraded to ceiling lift due to not standing in the stand aid. Correct type of sling	F 656	Immediate Corrective Action: R1, R3, & R4 care plans updated to reflect type and size of sling required during transfers with mechanical lifts. Corrective Action as it applies to others: All residents who require mechanical lifts reviewed to ensure proper size and type of sling being utilized and type and size of sling(s) added to the care plan. All nursing staff educated on proper sizing and type of slings for all mechanical lifts per manufacture guidelines. Date of Compliance: 1/20/2025 Recurrence will be prevented by: 5 residents that require mechanical lifts will be audited to ensure the proper size and type of sling is being utilized and their care plan is up to date. This will occur weekly x4 weeks then monthly times 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Director of Nursing or Designee	

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F 656	Continued From page 3 and size was used during transfer. Resident was in ceiling lift being transferred into bed from wheelchair. Resident was being lifted out of wheelchair and resident lifted arm straight up and fell to the floor. R1's significant change Minimum Data Set (MDS) dated 11/13/24, identified R1 required Substantial/max assist with transfers. R1's care plan reviewed on 12/30/24, identified assist with movement in and in/out bed A2 (assist of two persons) nonmechanical lift. Use hoyer/ceiling lift as needed if resident is unable to stand in non-mechanical stand aide. Assist with transfers requires minimum assist from elevated recliner for sit/stand into nonmechanical stand aid for transfers. Care plan failed to identify the type and size of sling to be used with transfers. R3's admission MDS dated 8/27/24, identified diagnoses of chronic gout, coronary artery disease, hypertension, and arthritis. R3 was identified as dependent on staff for transfers. R3's care plan reviewed on 12/30/24, identified R3 required a ceiling / hoyer lift for transfers. Care plan failed to identify the sling type or size used during transfers. R4's quarterly MDS dated 11/25/24, identified diagnoses of seizures and arthritis. R4 was identified as dependent on staff for transfers. R4's care plan reviewed on 12/31/24, identified R4 required a ceiling / hoyer lift for transfers. Care plan failed to identify the sling type or size used during transfers.	F 656		

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F 656	Continued From page 4 During interview on 12/30/24 at 1:13 p.m., nursing assistant (NA)-A confirmed being present during R1's fall on 12/22/24. NA-A was instructed to transfer R1 from wheelchair to bed. R1's care sheet identified R1 used a non-mechanical lift for transfers. Due to being unfamiliar with R1, NA-A confirmed R1's transfer status with another CNA and was instructed to use the ceiling lift due to R1 "having weakness in the evenings." NA-A placed a "half sling" on R1 which was in R1's room, began to raise R1 from wheelchair, R1 began to "flail," and slipped out of the sling. R1's lower body remained in the sling while R1's upper body fell to the ground. R1 hit her head on the ground during the fall and NA-A reported the fall to a nurse. During interview on 12/30/24 2:28 p.m., NA-B stated all residents who use a sling for transfers have their slings in their room. If uncertain about what sling size or type to use, would consult the care sheet. NA-B reviewed R1's care sheet and confirmed it listed the lift type but not sling size or type. During interview on 12/30/24 at 2:33 p.m., licensed practical nurse (LPN)-A stated if there was change in a resident's transfer status or if she "upgraded" the residents transfer status in an emergency, she would report this to nursing management and write a progress note. LPN-A would use the height / weight charts to select the correct sling. Each resident who uses a sling should have a sling in their room and the sling type should be listed on their care plan. During interview on 12/30/24 at 2:40 p.m., registered nurse (RN)-A confirmed R1's care plan and progress note from 12/22/24 did not list the	F 656		

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F 656	Continued From page 5 type or size sling to use for transfers. RN-A was unsure if the sling type or size was listed in the medical record of any resident who used a sling. RN-A stated R1 was assessed by the DON post fall and was upgraded to a full body sling. During interview on 12/30/24 at 3:11 p.m., DON stated any nursing staff can "upgrade" a resident from a non-mechanical to mechanical lift for safety. To select the correct sling, nursing staff are expected to use the manufacturers height and weight sling chart(s) posted at the nursing stations and should report any changes in sling/lift use to nursing management. The facility does not use a formal sling assessment form and the specific sling type and size used was not documented in the resident's care plan. The care plan includes lift type but not sling type. During observation on 12/31/24 from 8:43 a.m. to 11:01 a.m., resident's rooms who required lifts were audited for correct sling size based on size chart at nurse's station. The slings in resident rooms were correct based on manufacture chart guidelines. During interview on 12/31/24 at 4:40 p.m., the administrator expected all residents who require a sling for transfers are using the appropriate slings to ensure the safety of the residents and staff. Using an improper sling could result in anything from pinching and being uncomfortable to falls and injury. During interview on 12/31/24 at 4:41 p.m., DON indicated a comprehensive care plan was important as it directs resident care and plans to update the care plan(s) to include sling type and size for residents who use mechanical lifts.	F 656		

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F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly assess, care plan, and ensure the correct sling was used during transfers for 1 or 1 resident (R1) reviewed for mechanical lift transfers. The resident was transferred using a ceiling lift with a reported toileting sling (a sling which does not cover the buttocks) of unknown size, fell out of the sling during the transfer, and sustained a laceration to the back of head. The deficient practice was identified as an immediate jeopardy (IJ) situation, however, the provider had implemented corrective action prior to the investigation, therefore, the deficiency was issued as past non-compliance. The IJ began on 12/22/24 at 8:10 p.m., when R1 was transferred with a ceiling lift using a reported toileting sling of unknown size. R1 slipped out of the sling during the transfer which resulted in R1's head hitting the ground and sustaining a laceration to the back of the head. The administrator and director of nursing (DON) were informed of the IJ on 12/31/24 at 4:45 p.m. The facility implemented corrective action on 12/23/24, prior to the start of the survey, therefore, was past non-compliance.	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 7 Findings include: R1's incident report from 12/22/24, identified R1 was admitted to the facility on 6/11/24, with a primary diagnosis of chronic combined systolic and diastolic (congestive) heart failure (heart unable to pump enough blood to organs) and nonrheumatic aortic stenosis (narrowing of heart valve). R1's last brief interview for mental status (BIMS) was on 11/13/24 which showed moderate cognitive impairment. Incident report described the accident as follows: "NAR was transferring resident via ceiling lift from wheelchair to bed when resident put her arms up which caused her to slide through. LPN stated she walked in, and resident was on the floor. It was noted resident had a bump that was bleeding on back of head, vitals stable, A&O, eyes equal and reactive to light, pain level 5/10, pain medication given. Pressure bandage placed on the back of head. Hospice and family notified." R1's significant change Minimum Data Set (MDS) dated 11/13/24, identified R1 required substantial/max assist with transfers. R1's care plan reviewed on 12/30/24, identified assist with movement in and in/out bed A2 (assist of two persons) nonmechanical lift. Use Hoer/ceiling lift as needed if resident is unable to stand in non-mechanical stand aide. Assist with transfers requires minimum assist from elevated recliner for sit/stand into nonmechanical stand aid for transfers. R1's progress note dated 12/22/24 at 8:34 p.m., identified resident has not been standing up for	F 689		

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	245277	A. BUILDING _____ B. WING _____	C 12/31/2024

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lift, she can't lift herself to stand.

R1's progress note dated 12/22/24 at 8:37 p.m., identified resident upgraded to ceiling lift due to not standing in the stand aid. Correct type of sling and size was used during transfer. Resident was in ceiling lift being transferred into bed from wheelchair. Resident was being lifted out of wheelchair and resident lifted arm straight up and fell to the floor.

During interview on 12/30/24 at 12:38 p.m., R1 stated "they dropped me." R1 explained during a recent transfer using a ceiling lift she "slipped out" of the sling and hit her head on the ground. R1 stated her head hurt after the fall but was unable to quantify her pain level.

During interview on 12/30/24 at 1:13 p.m., nursing assistant (NA)-A confirmed being present during R1's fall on 12/22/24. This was NA-A's second day working at the facility and first time working with R1. NA-A was instructed to transfer R1 from wheelchair to bed. R1's care sheet identified R1 used a non-mechanical lift for transfers. Due to being unfamiliar with R1, NA-A confirmed R1's transfer status with another CNA and was instructed to use the ceiling lift due to R1 "having weakness in the evenings." NA-A was informed R1 tends to flail during transfers with ceiling lift. NA-A placed a "half sling" on R1 which was in R1's room, began to raise R1 from wheelchair, R1 began to "flail," and slipped out of the sling. R1's lower body remained in the sling while R1's upper body fell to the ground. R1 hit her head on the ground during the fall and NA-A reported the fall to a nurse.

During interview on 12/30/24 2:28 p.m., NA-B

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stated all residents who use a sling for transfers have their slings in their room. If uncertain about what sling size or type to use, would consult the care sheet.

During interview on 12/30/24 at 2:33 p.m., licensed practical nurse (LPN)-A stated if there was change in a resident's transfer status, she would report this to nursing management. If nursing management was not available and it was a "safety issue" she would upgrade the resident's lift/sling type. She would select the correct sling by consulting the sling size chart(s) at the nursing station, write a progress note, and report the change to nursing management. Each resident who uses a sling should have a sling in their room.

During interview on 12/30/24 at 2:40 p.m., registered nurse (RN)-A confirmed R1's care plan and progress note from 12/22/24 did not list the type or size sling to use for transfers. RN-A was unsure if the sling type or size was listed in the medical record of any resident who used a sling. RN-A stated R1 was assessed by the director of nursing (DON) post fall and was upgraded to a full body sling.

During interview on 12/30/24 at 3:11 p.m., DON stated any nursing staff can "upgrade" a resident from a non-mechanical to mechanical lift for safety. To select the correct sling, nursing staff are expected to use the manufacturers height and weight sling chart(s) posted at the nursing stations and should report any changes in sling/lift use to nursing management. The facility does not use a formal sling assessment form and the specific sling type and size used was not documented in the resident's medical record. The

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F 689	Continued From page 10 appropriate sling should always be in the resident's room and if staff are unaware what size/type of sling to use they should consult with another staff member and/or the manufactures height and weight chart(s). DON stated R1 had not been using the ceiling lift prior to the fall on 12/22/24 and the use of a sling for R1 should be "signed off" by a register nurse prior to its continued use. DON reported on 12/23/24 she completed a sling assessment on R1 and determined due to R1's inability to keep arms on the outside of a toileting sling, R1 required a full body sling and the assist of 2 during transfers with the ceiling lift. During interview on 12/31/24 at 8:25 a.m., trained medical aid (TMA)-A stated during an emergency all nursing staff can implement the use of a sling, but only "half back slings." An assessment by an RN or physical therapy was needed for a full sling. To implement a sling, the sling charts need to be consulted to determine the correct size and this should be reported to nursing management who document the sling. Any available staff member can obtain a sling from the "sling room." During interview and observation on 12/31/24 at 8:58 a.m., NA-C identified as being "pool staff" and stated slings were always in the resident's room and only facility staff were able to obtain slings. NA-C located the sling in R4's room and identified it was a Guldman, size medium toileting sling. While R4 was in wheelchair, NA-C proceeded to place the back of the sling across R4's back and leg straps under R4's legs. NA-C crossed the leg stapes, moved the ceiling lift towards R4, properly connected the upper and lower body sling strap loops to the ceiling lift. NA-C instructed R4 to keep arms outside of and	F 689		

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hold on to sling. NA-C slowly raised R4 from wheelchair and transferred to bed making sure R4's body was in proper alignment prior to lowering the lift. When R4 was fully lowered onto the bed, NA-C removed the sling loops from the lift, moved the sling away from R4's lower body, and pushed the lift a safe distance away from R4 before proceeding with cares. R4 reviewed and determined to be using the proper sling size based on manufactures guidelines.

During interview on 12/31/24 at 11:13 a.m., LPN-A confirmed being the nurse who responded to R1's fall on 12/22/24. Prior to the fall, LPN-A had made the determination to "upgrade" R1 from a non-mechanical lift to the ceiling lift due to weakness. LPN-A did not select the sling size/type and used the sling that was already in R1's room, which was described as "not a full body" sling of unknown size. LPN-A stated R1 has been having intermittent weakness in the evening and has been using the ceiling lift for a while. As a result of the fall, R1 sustained a laceration to the back of her head which required a pressure bandage and per hospice nurse evaluation did not require stitches. LPN-A stated when selecting what sling to use, she does not take measurements of the resident or reference any manufacturers chart(s) to determine what sling size to use. Sling was selected based on how it fits around the residents back.

During follow up interview on 12/31/24 at 11:52 a.m., DON was unaware R1 was using a ceiling lift prior to 12/22/24 and would expect this change to be reported. DON stated there was no way to determine when R1 began to use the ceiling lift unless a progress note was made as expected,

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F 689	Continued From page 12 but this does not always happen. In response to the fall, the DON stated on 12/23/24, the DON and administration re-assessed all residents who use a sling to ensure the correct size and type was being used. Aside from R1, no change in sling type/size was needed. All direct care staff were required to complete mechanical stands competency prior to the start of next shift. During observation on 12/31/24 from 8:43 a.m. to 11:01 a.m., residents rooms who were required lifts were audited for correct sling size based on size chart at nurses station. The slings in resident rooms were correct based on manufacture chart guidelines. During document review on 12/31/24, signed copies of direct care staff mechanical stands competencies dated 12/23/24 to 12/31/24, outlined how to utilize mechanical stands, including how to apply slings, per manufacturer guidelines and facility policy and procedure. During interview on 12/31/24 at 4:40 p.m., the administrator expected all residents who require a sling for transfers are using the appropriate slings to ensure the safety of the residents and staff. Using an improper sling could result in anything from pinching and being uncomfortable to falls and injury. A policy for mechanical lift and sling use was requested, but not provided. Facility identified they do not have a specific policy but follow manufacturers guidelines. The facility implemented corrective action to prevent recurrence by 12/23/24, when the facility implemented a systemic plan that included the	F 689		

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F 689	Continued From page 13 following actions: On 12/23/24 DON completed a sling assessment on R1 and determined a full body sling with the assist of 2 was required during ceiling lift transfers. On 12/23/24, all residents who use mechanical lifts were re-assessed for the correct sling size and type. Starting on 12/23/24 all direct care staff were required to complete a mechanical stand use competency prior to the start of their next shift.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 10, 2025

Administrator
The Waterview Woods LLC
601 Grant Avenue
Eveleth, MN 55734

Re: Event ID: 1WML11

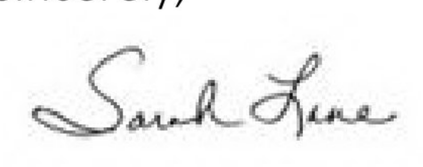
Dear Administrator:

The above facility survey was completed on December 31, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/30/24 through 12/31/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed: H52773563C (MN00109320) and H52773681C	2 000		

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2 000	Continued From page 1 (MN00108492) NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		