DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 21, 2025

Administrator
The Waterview Pines LLC
1201 8TH STREET SOUTH
PO BOX 971
VIRGINIA, MN 55792

RE: CCN: 245283
Cycle Start Date: July 24, 2025

Dear Administrator:

On August 28, 2025, we notified you a remedy was imposed. On September 23, 2025, the Minnesota Departments of Health and Public Safety 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 September 02, 2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective September 12, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of August 28, 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 September 12, 2025. 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

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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November 21, 2025

Administrator
The Waterview Pines LLC
1201 8TH STREET SOUTH
PO BOX 971
VIRGINIA, MN 55792

Re: Reinspection Results
Event ID: 1D34E8-H2

Dear Administrator:

On September 23, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 12, 2025. At this time these correction orders were found corrected.

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

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An equal opportunity employer.

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August 28, 2025

Administrator
The Waterview Pines LLC
1201 8TH STREET SOUTH
PO BOX 971
VIRGINIA, MN 55792

RE: CCN: 245283
Cycle Start Date: 07/24/2025

Dear Administrator:

On 08/01/2025, we informed you that we may impose enforcement remedies.

On 08/12/2025, the Minnesota Department(s) of Health completed a survey, and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety.

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On 08/08/2025, the situation of immediate jeopardy to potential health and safety cited at F689 - Free of Accident Hazards/Supervision/Devices was removed. However, continued non-compliance remains at the lower scope and severity of D.

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:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective 09/12/2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective 09/12/2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective 09/12/2025.

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.

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 Pines LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 12, 2025. 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.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

Susie Haben, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

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 January 24, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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:

tamika.brown@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 tamika.brown@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)

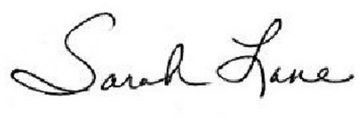
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP

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.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 28, 2025

Administrator
The Waterview Pines LLC
1201 8TH STREET SOUTH
PO BOX 971
VIRGINIA, MN 55792

Re: State Nursing Home Licensing Orders
Event ID: 1D34E8-H1

Dear Administrator:

The above facility survey was completed on 08/12/2025 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 one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susie Haben, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557

Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterview Pines LLC	**1201 8TH STREET SOUTH PO BOX 971, VIRGINIA, Minnesota, 55792**

(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
F0000	INITIAL COMMENTS On 8/6/25/25 through 8/8/25, and 8/12/25 a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H52831385C (2579501, 2579371), with a deficiency cited at F689. As a result of the survey additional deficiencies were cited at F609, F610. The immediate jeopardy began on 8/1/25, when R1 fell while being transferred in a full body mechanical lift and fell out of the lift during transfer, resulting in a serious injury. The facility failed to identify if the staff were correctly using the lift per manufacturer recommendation when the incident occurred and failed to review other residents at risk to ensure proper use of mechanical lifts to prevent future falls. Additional transfer observations identified manufacturer's guidelines were not followed for safe use. The IJ was identified on 8/7/25. The administrator and director of nursing (DON) were notified of the immediate jeopardy at 2:30 p.m. on 8/7/25. The IJ was removed on 8/8/25 at 1:30 p.m., but non-compliance remained at the lower scope and severity level D, which indicated no actual harm with potential for minimal harm that is not immediate jeopardy. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. 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.	F0000		09/02/2025
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F0609	F609 Reporting of Alleged Violations Immediate Corrective Action:	09/02/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/12/2025

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F0609 SS = D	Continued from page 1 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to report an allegation of neglect of care related to a fall from a mechanical lift to the state agency (SA) for 1 of 3 residents reviewed for use of mechanical lifts. R1's Admission Record indicated she admitted to the facility 6/1/23. R1's diagnosis included dementia with behavioral disturbance, back pain, other chronic pain, and spinal stenosis. R1's care plan dated 6/30/25, identified an alteration in cognition and an alteration in mobility. The care plan directed staff to transfer R1 via celling lift using a toileting sling when using the toilet and a full body split leg sling for all other transfers. R1's Incident Review and Analysis dated 8/1/25, indicated Staff was transferring R1 from the bathroom to the bed using a toileting sling and R1 fell out onto the floor and hit her head.	F0609	Continued from page 1 All staff were educated to report alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately. Corrective Action as it applies to others: The Abuse Prohibition Vulnerable Adult Policy was reviewed and remains current. All cognitively intact residents were interviewed to ensure that they don’t have any concerns with staff that have not been addressed. All staff were educated on reporting allegations of abuse/mistreatment to DON/Administrator immediately. Date of Compliance: 9/2/2025 Recurrence will be prevented by: 5 residents or responsible representatives will be interviewed to ensure that they don’t have any concerns with staff or their cares. This will occur weekly x4 weeks then monthly time 2 times. These results will be shared with the facility QAPI committee to increase, decrease or discontinue audits. Corrections will be monitored by: Director of Nursing or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterview Pines LLC	1201 8TH STREET SOUTH PO BOX 971, VIRGINIA, Minnesota, 55792

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F0609 SS = D	Continued from page 2 During interview with the administrator and DON on 8/6/25 at 4:46 p.m., the administrator stated R1 was in a toileting sling and she fell through because she placed her arms inside the sling. The administrator stated the incident had not been reported to the SA because the care plan had been followed during the transfer. During interview on 8/7/25 at 8:44 a.m., the facility's ceiling lift representative (R)-A stated typically when an accident happened during transfer in a lift, something would have been wrong with the way the sling was used or applied. R-A said the toileting slings used with the ceiling lift required the resident to keep their arms outside the sling. R-A said with the toileting sling, size was a much bigger deal because there was more open area. R-A stated if a resident did not have the cognitive or physical ability to keep their arms outside the sling, the toileting sling would not be recommended. R-A said if the sling used during transfer was appropriate for the resident, a fall from the lift should not have happened. During interview on 8/7/25 at 9:00 a.m., nursing assistant (NA)-A stated she had been transferring R1 from the wheelchair to the bed, not from the toilet, and said during the transfer, R1 put her arms through the sling and had been confused and tired. NA-A said R1 had been resting her hands on her legs on her lap. NA-A said she had watched R1 put her arms inside the sling and had told her to keep her arms outside the sling. NA-A said she tried to catch R1 when she fell and they both fell. She said the wheelchair was positioned parallel to the bed with a floor mat between the bed and the chair but said R1 had landed on the floor at the end of the bed. NA-A said she had used the correct sling size and had used the toileting sling. However, R1's care plan directed the use of a full body sling for transfers when not using the toilet. Facility policy Abuse Prohibition/Vulnerable Adult dated 4/2025, indicated all staff are responsible for reporting situation that is considered abuse or neglect, defined as the facility failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Suspected abuse shall be reported to the SA no later than two hours after forming the suspicion of abuse.	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F0610	F610 Investigate/Prevent/Correct Alleged Violation Immediate Corrective Action:	09/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/12/2025

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The Waterview Pines LLC	1201 8TH STREET SOUTH PO BOX 971, VIRGINIA, Minnesota, 55792

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F0610 SS = D	Continued from page 3 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to thoroughly investigate a fall from a lift resulting in significant injury for 1 of 3 residents (R1) reviewed for neglect of care. R1's Admission Record indicated she admitted to the facility 6/1/23. R1's diagnosis included dementia with behavioral disturbance, back pain, other chronic pain, and spinal stenosis. R1's quarterly Minimum Data Set (MDS) dated 6/30/25, identified severe cognitive impairment and indicated she displayed no behaviors. The care plan indicted R1 was dependent on staff for transfers and was always incontinent of bowel and bladder. R1's Lift/Mobility Status Form dated 10/7/24, indicated she was unable to bear weight, was unable to follow simple instructions and was not cooperative with transfers. The form indicated use of a ceiling lift with assistance from one staff. R1's care plan dated 6/30/25, identified an alteration in cognition and an alteration in mobility. The care plan directed staff to transfer R1 via celling lift using a toileting sling when using the toilet and a full body split leg sling for all other transfers. R1's Incident Review and Analysis dated 8/1/25,	F0610	Continued from page 3 Immediate investigation conducted on R1. Corrective Action as it applies to others: The Abuse Prohibition/Vulnerable Adult Policy was reviewed and remains current. All resident incidents regarding potential alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately will be conducted within appropriate timeframe. All resident violations will be filed, investigated, and followed up on per policy. Administrator/DON/Designee educated on obtaining evidence that all alleged violations are thoroughly investigated. Date of Compliance: 9/2/2025 Recurrence will be prevented by: All resident incidents listed above will be audited weekly x4 weeks then monthly x2 to ensure proper investigation and follow up are per policy. These results will be shared with the facility QAPI committee to increase, decrease or discontinue audits. Corrections will be monitored by: Administrator or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245283	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0610 SS = D	Continued from page 4 indicated Staff was transferring R1 from the bathroom to the bed using a toileting sling and R1 fell out onto the floor and hit her head. R1's Progress note dated 8/1/25, indicated she was lowered to the floor by staff after assisting her from toilet to bed. During transfer R1 let go of the sling and began to slide through the sling. Correct sling, correct brand and care plan followed. R1 had a small laceration to the back of her head and was transported to the emergency department (ED) for evaluation. R1's incident report dated 8/1/25, indicated she was lowered to the floor by staff after assisting from toilet to bed. During transfer R1 let go of the sling and began to slide through the sling. Staff put her arms around R1 and lowered R1 to the floor. Correct sling, size, brand and care plan followed. R1 had small laceration to the back of her head. R1's hospital History and Physical dated 8/4/25, indicated R1 was admitted for fall, trauma, non-surgical fractures and pain control. She was brought the ED for evaluation. She had been lifted on a mechanical lift and fell 3-4 feet, falling on her head onto a hardwood floor. Discharge diagnosis included fracture of left clavicle (collarbone), scalp hematoma (localized collection of blood outside the blood vessels), fracture of one rib and concussion. An untitled, undated facility investigation provided by the administrator indicated on 8/1/25, R1 was lowered to the floor by staff. Nursing assistant (NA) stated R1 was placed in the sling correctly, hooked to the ceiling lift, legs were crossed. As the NA lifted R1 she noticed R1's bottom was slipping down. The NA grabbed R1 around the waist. R1 had put her arms inside the sling which resulted in her sliding down in the sling further. R1's feet were still in the sling but NA lowered her to the floor. The director of nursing (DON) confirmed the care plan was followed, appropriate way to transfer, correct sling, correct brand and size and lift was in working condition. NA demonstrated how the transfer was performed from start to finish including action taken when R1 began sliding down. The investigation did not include an interview with the NA who had performed the transfer. During interview with the administrator and DON on 8/6/25 at 4:46 p.m., the administrator stated R1 was in a toileting sling and she fell through because she placed her arms inside the sling. The DON stated based on the interview with the NA, R1 had let go of the sling and put her arms inside of it resulting in the	F0610		

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F0610 SS = D	Continued from page 5 fall. The DON stated she had talked to the NA after the incident and said she and the administrator had made a follow up call with the NA but had not documented either conversation. The DON further stated the NA had completed a return demonstration of how to properly use the lift which also had not been documented. During interview on 8/7/25 at 8:44 a.m., the facility's ceiling lift representative (R)-A stated typically when an accident happened during transfer in a lift, something would have been wrong with the way the sling was used or applied. R-A said the toileting slings used with the ceiling lift required the resident to keep their arms outside the sling. R-A said with the toileting sling, size was a much bigger deal because there was more open area. R-A stated if a resident did not have the cognitive or physical ability to keep their arms outside the sling, the toileting sling would not be recommended. R-A said if the sling used during transfer was appropriate for the resident, a fall from the lift should not have happened. During interview on 8/7/25 at 9:00 a.m., nursing assistant (NA)-A stated she had been transferring R1 from the wheelchair to the bed, not from the toilet, and said during the transfer, R1 put her arms through the sling and had been confused and tired. NA-A said R1 had been resting her hands on her legs on her lap. NA-A said she had watched R1 put her arms inside the sling and had told her to keep her arms outside the sling. NA-A said she tried to catch R1 when she fell and they both fell. She said the wheelchair was positioned parallel to the bed with a floor mat between the bed and the chair but said R1 had landed on the floor at the end of the bed. NA-A said she had used the correct sling size and had used the toileting sling. However, R1's care plan directed the use of a full body sling for transfers when not using the toilet. Facility policy Abuse Prohibition/Vulnerable Adult dated 4/2025, indicated investigation shall begin immediately. Staff will take immediate action to prevent further abuse/neglect while the investigation is in process. Investigation may include interviews with staff, residents or other witnesses to the event. Corrective action based on the investigation will be completed (e,g,, change of procedure, training, discipline or discharge of staff, etc.)	F0610		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689	Immediate Corrective Action: R1 discharged prior to POC. Corrective Action as it applies to others:	09/02/2025

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F0689 SS = SQC-J	Continued from page 6 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 develop and implement a procedure to determine appropriate sling types for 3 residents (R1, R2, R3) assessed to require the use of mechanical lift for transfers. This resulted in a fall from a ceiling lift resulting in non-surgical fractures and a head laceration for R1 and observation of the wrong sling size, sling type in their room or being used by staff for R2 and R3. This resulted in immediate jeopardy (IJ) for R1, R2 and R3. The immediate jeopardy began on 8/1/25, when R1 fell while being transferred in a full body mechanical lift and fell out of the lift during transfer, resulting in a serious injury. The facility failed to identify if the staff were correctly using the lift per manufacturer recommendation when the incident occurred and failed to review other residents at risk to ensure proper use of mechanical lifts to prevent future falls. Additional transfer observations identified manufacturer's guidelines were not followed for safe use. The IJ was identified on 8/7/25. The administrator and director of nursing (DON) were notified of the immediate jeopardy at 2:30 p.m. on 8/7/25. The IJ was removed on 8/8/25 at 1:30 p.m., but non-compliance remained at the lower scope and severity level D, which indicated no actual harm with potential for minimal harm that is not immediate jeopardy. Findings include: R1's Admission Record indicated she admitted to the facility 6/1/23. R1's diagnosis included dementia with behavioral disturbance, back pain, other chronic pain, and spinal stenosis. R1's quarterly Minimum Data Set (MDS) dated 6/30/25, identified severe cognitive impairment and indicated	F0689	Continued from page 6 All residents requiring slings measured for appropriate size/type/brand according to manufacturer guidelines and information added into care plan. All licensed nurses, TMA's and NAR's were educated on proper sizing/type/brand per manufacturer guidelines. All licensed nurses educated on facility developed procedure to determine sling size and type. Facility procedure revised to include additional detail added into mobility form including sling size and type. Date of Compliance: 9/2/2025 Recurrence will be prevented by: 5 residents will be checked to ensure they have the correct size/type/brand sling and correct documentation is listed in care plans weekly x4 weeks then monthly x2. These results will be shared with the facility QAPI committee to increase, decrease or discontinue audits. Corrections will be monitored by: Administrator or Designee	

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F0689 SS = SQC-J	Continued from page 7 she displayed no behaviors. The care plan indicted R1 was dependent on staff for transfers and was always incontinent of bowel and bladder. R1's Lift/Mobility Status Form dated 10/7/24, indicated she was unable to bear weight, was unable to follow simple instructions and was not cooperative with transfers. The form indicated use of a ceiling lift with assistance from one staff. R1's care plan dated 6/30/25, identified an alteration in cognition and an alteration in mobility. The care plan directed staff to transfer R1 via celling lift using a toileting sling when using the toilet and a full body split leg sling for all other transfers. R1's Incident Review and Analysis dated 8/1/25, indicated staff was transferring R1 from the bathroom to the bed using a toileting sling when R1 fell out onto the floor and hit her head. R1's Progress note dated 8/1/25, indicated she was lowered to the floor by staff after assisting her from toilet to bed. During transfer R1 let go of the sling and began to slide through the sling. Correct sling, correct brand and care plan followed. R1 had a small laceration to the back of her head and was transported to the emergency department (ED) for evaluation. R1's incident report dated 8/1/25, indicated she was lowered to the floor by staff after assisting from toilet to bed. During transfer R1 let go of the sling and began to slide through the sling. Staff put her arms around R1 and lowered R1 to the floor. Correct sling, size, brand and care plan followed. R1 had small laceration to the back of her head. R1's hospital History and Physical dated 8/4/25, indicated R1 was admitted for fall, trauma, non-surgical fractures and pain control. She was brought the ED for evaluation. She had been lifted on a mechanical lift and fell 3-4 feet, falling on her head onto a hardwood floor. Discharge diagnosis included fracture of left clavicle (collarbone), scalp hematoma (localized collection of blood outside the blood vessels), fracture of one rib and concussion.	F0689		

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F0689 SS = SQC-J	Continued from page 8 During interview on 8/6/25 at 5:12 p.m., the director of nursing (DON) stated the Lift/Mobility Status form was completed upon admission, quarterly and with a change of condition. The DON stated after R1 fell they had made sure the proper sized sling had been used. The DON stated if R1 brought her arms inside the sling during the transfer, it could have caused her to fall. During interview on 8/7/25 at 8:44 a.m., the facility's ceiling lift representative (R)-A stated typically when an accident happened during transfer in a lift, something would have been wrong with the way the sling was used or applied. R-A said the toileting slings used with the ceiling lift required the resident to keep their arms outside the sling. R-A said with the toileting sling, size was a much bigger deal because there was more open area. R-A stated if a resident did not have the cognitive or physical ability to keep their arms outside the sling, the toileting sling would not be recommended. R-A said if the sling used during transfer was appropriate for the resident, a fall from the lift should not have happened. During interview on 8/7/25 at 9:00 a.m., nursing assistant (NA)-A stated she had been transferring R1 from the wheelchair to the bed, not from the toilet, and said during the transfer, R1 put her arms through the sling and had been confused and tired. NA-A said R1 had been resting her hands on her legs on her lap. NA-A said she had watched R1 put her arms inside the sling and had told her to keep her arms outside the sling. NA-A said she tried to catch R1 when she fell and they both fell. She said the wheelchair was positioned parallel to the bed with a floor mat between the bed and the chair but said R1 had landed on the floor at the end of the bed. NA-A stated she had used the correct sling size and had used the toileting sling. However, R1's care plan directed the use of a full body sling for transfers when not using the toilet. R2's Admission Record indicated he admitted to the facility 1/28/20. R2's diagnosis included hemiplegia and hemiparesis, instability of left ankle, chronic pain and mild dementia. R2's quarterly MDS dated 4/30/25, identified moderate cognitive impairment and rejection of care behaviors 1 -3 days during the assessment period. The MDS indicated R2 was dependent on staff for transfers.	F0689		

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F0689 SS = SQC-J	Continued from page 9 R2's Lift/Mobility Status Form dated 1/30/24, indicated he could bear weight on at least one leg, was cooperative with transfers and was able to follow simple instructions. Lift to be utilized indicated a manual sit/stand lift. R2's care plan dated 8/4/25, identified an alteration in cognition with noted impairments in short term memory and an alteration in mobility related to weakness and lack of coordination. The care plan directed staff to transfer R2 using a ceiling lift and size small toileting sling or mechanical lift using a size small full body split leg sling. During observation on 8/6/25 at 4:00 p.m., R2 had a sling laying on top of his bed. The sling was yellow with black edges and was labeled size medium. During observation on 8/6/25 at 4:57 a.m., with the administrator present, R2 was observed to have a size small sling on his bed. R2 stated "they just switched it." R2 said the one used previously that day had been the wrong size and said earlier he had slid through the sling and using his hands demonstrated approximately 6 -8 inches from the floor. During interview on 8/6/258 at 5:05 p.m., the administrator said R2 had been transferred earlier with the ceiling lift and the sling "adjusted." The administrator said there was no concern with the lift hook up or sling size per R2. The administrator stated there had been no follow up with staff to verify if the appropriate sling had been used but said the care plan had been followed. During interview on 8/7/25 at 3:22 p.m., family member (FM)-A stated she was present when R2 slipped through the toileting sling. FM-A said she was not sure what happened but said R2 was about a foot above the bed and he slipped through and landed on his butt and back on the bed. FM-A said she thought the slings were one size fits all and said staff had used a larger sling before. R2 was present and said, "I fell out the bottom, that's why they brought me a new one," referring to the sling. R3's Admission Record indicated she admitted to the facility 4/16/23. R3's diagnosis included dementia,	F0689		

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F0689 SS = SQC-J	Continued from page 10 anxiety, right above knee amputation and chronic pain. R3's quarterly MDS dated 4/9/25, identified a memory problem and indicated she displayed physical, verbal and rejection of care behaviors 1-3 days during the assessment period. The MDS indicated R3 was dependent on staff for transfers. R3's Mobility/Lift Status Form dated 1/8/25, identified an amputation and indicated she could not bear weight and was not cooperative with transfers. The form identified the use of a ceiling lift. During observation on 8/6/25 at 4:13 p.m., NA-C and NA-D prepared to transfer R3. R3 was lying in bed and had a toileting sling underneath her. NA-C and NA-D switched the sling for a full body sling as directed in the care plan. NA-C stated the sling underneath R3 was not the correct sling. NA-D said the staff on the previous shift had used the wrong sling to transfer R3. During interview on 8/7/25 at 10:43 a.m., registered nurse (RN)-A stated slings were assessed on admission, quarterly and with a change of condition. RN-A stated sling size and type were based on height and weight of the resident and said sling type was based on whether the resident was continent or not. RN-A said a toileting sling would not be used if there were physical limitations such as an amputation or if the resident was agitated or displayed behaviors and could go through the sling. RN-A said the toileting sling was appropriate for R1 even though R1's Lift form indicated she was unable to follow simple instructions and was not cooperative with transfers, because R1 still used the toilet. Facility Policy Sare Patient Handling dated 3/2020, indicated safe patient handling is a key component to providing employees a safe work environment, while providing high quality resident care. Specifically, mechanical lift equipment and/or other approved patient moving aides/devices should be used in all circumstances when liftin/moving residents except when manual assistance is deemed absolutely necessary. All resident care will be provided in a safe, appropriate and timely manner in accordance with the residents plan of care.	F0689		

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F0689 SS = SQC-J	Continued from page 11 The immediate jeopardy began on 8/1/25. The immediate jeopardy was removed 8/8/25, after the facility implemented a systemic plan that included the following actions: - Developed and implemented a system to determine appropriate sling size/use based on resident need and manufacturer's guidelines for R1, R2, and R3. -Assessed all residents who required the use of an assistive device to ensure correct sling was in use. -Ensured staff were educated to that process and where to find information regarding accurate sling per resident. - Developed a procedure related to assessment of resident sling use. -Educated staff responsible for transferring residents to the above policies, procedures, and changes made prior to the beginning of their next shift.	F0689		

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20000	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 8/6/25 through 8/8/25 and 8/12/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		09/02/2025

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

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20000	Continued from page 1 The following complaint was reviewed. H52831385C (2579501, 2579371) with a licensing order issued at (0830.) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must	20830	Corrected	09/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterview Pines LLC	**1201 8TH STREET SOUTH PO BOX 971, VIRGINIA, Minnesota, 55792**

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20830	Continued from page 2 be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to develop and implement a procedure to determine appropriate sling types for 3 residents (R1, R2, R3) assessed to require the use of mechanical lift for transfers. This resulted in a fall from a ceiling lift resulting in non-surgical fractures and a head laceration for R1 and observation of the wrong sling size, sling type in their room or being used by staff for R2 and R3. Findings include: R1's Admission Record indicated she admitted to the facility 6/1/23. R1's diagnosis included dementia with behavioral disturbance, back pain, other chronic pain, and spinal stenosis. R1's quarterly Minimum Data Set (MDS) dated 6/30/25, identified severe cognitive impairment and indicated she displayed no behaviors. The care plan indicted R1 was dependent on staff for transfers and was always incontinent of bowel and bladder R1's Lift/Mobility Status Form dated 10/7/24, indicated she was unable to bear weight, was unable to follow simple instructions and was not cooperative with transfers. The form indicated use of a ceiling lift with assistance from one staff. R1's care plan dated 6/30/25, identified an alteration in cognition and an alteration in mobility. The care plan directed staff to transfer R1 via celling lift using a toileting sling when using the toilet and a full body split leg sling for all other transfers. R1's Incident Review and Analysis dated 8/1/25, indicated staff was transferring R1 from the bathroom to the bed using a toileting sling when R1 fell out onto the floor and hit her head. R1's Progress note dated 8/1/25, indicated she was lowered to the floor by staff after assisting her from	20830		

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20830	Continued from page 3 toilet to bed. During transfer R1 let go of the sling and began to slide through the sling. Correct sling, correct brand and care plan followed. R1 had a small laceration to the back of her head and was transported to the emergency department (ED) for evaluation. R1's incident report dated 8/1/25, indicated she was lowered to the floor by staff after assisting from toilet to bed. During transfer R1 let go of the sling and began to slide through the sling. Staff put her arms around R1 and lowered R1 to the floor. Correct sling, size, brand and care plan followed. R1 had small laceration to the back of her head. R1's hospital History and Physical dated 8/4/25, indicated R1 was admitted for fall, trauma, non-surgical fractures and pain control. She was brought the ED for evaluation. She had been lifted on a mechanical lift and fell 3-4 feet, falling on her head onto a hardwood floor. Discharge diagnosis included fracture of left clavicle (collarbone), scalp hematoma (localized collection of blood outside the blood vessels), fracture of one rib and concussion. During interview on 8/6/25 at 5:12 p.m., the director of nursing (DON) stated the Lift/Mobility Status form was completed upon admission, quarterly and with a change of condition. The DON stated after R1 fell they had made sure the proper sized sling had been used. The DON stated if R1 brought her arms inside the sling during the transfer, it could have caused her to fall. During interview on 8/7/25 at 8:44 a.m., the facility's ceiling lift representative (R)-A stated typically when an accident happened during transfer in a lift, something would have been wrong with the way the sling was used or applied. R-A said the toileting slings used with the ceiling lift required the resident to keep their arms outside the sling. R-A said with the toileting sling, size was a much bigger deal because there was more open area. R-A stated if a resident did not have the cognitive or physical ability to keep their arms outside the sling, the toileting sling would not be recommended. R-A said if the sling used during transfer was appropriate for the resident, a fall from the lift should not have happened. During interview on 8/7/25 at 9:00 a.m., nursing assistant (NA)-A stated she had been transferring R1	20830		

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20830	Continued from page 4 from the wheelchair to the bed, not from the toilet, and said during the transfer, R1 put her arms through the sling and had been confused and tired. NA-A said R1 had been resting her hands on her legs on her lap. NA-A said she had watched R1 put her arms inside the sling and had told her to keep her arms outside the sling. NA-A said she tried to catch R1 when she fell and they both fell. She said the wheelchair was positioned parallel to the bed with a floor mat between the bed and the chair but said R1 had landed on the floor at the end of the bed. NA-A stated she had used the correct sling size and had used the toileting sling. However, R1's care plan directed the use of a full body sling for transfers when not using the toilet. R2's Admission Record indicated he admitted to the facility 1/28/20. R2's diagnosis included hemiplegia and hemiparesis, instability of left ankle, chronic pain and mild dementia. R2's quarterly MDS dated 4/30/25, identified moderate cognitive impairment and rejection of care behaviors 1 -3 days during the assessment period. The MDS indicated R2 was dependent on staff for transfers. R2's Lift/Mobility Status Form dated 1/30/24, indicated he could bear weight on at least one leg, was cooperative with transfers and was able to follow simple instructions. Lift to be utilized indicated a manual sit/stand lift. R2's care plan dated 8/4/25, identified an alteration in cognition with noted impairments in short term memory and an alteration in mobility related to weakness and lack of coordination. The care plan directed staff to transfer R2 using a ceiling lift and size small toileting sling or mechanical lift using a size small full body split leg sling. During observation on 8/6/25 at 4:00 p.m., R2 had a sling laying on top of his bed. The sling was yellow with black edges and was labeled size medium. During observation on 8/6/25 at 4:57 a.m., with the administrator present, R2 was observed to have a size small sling on his bed. R2 stated "they just switched it." R2 said the one used previously that day had been the wrong size and said earlier he had slid through the	20830		

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20830	Continued from page 5 sling and using his hands demonstrated approximately 6 -8 inches from the floor. During interview on 8/6/258 at 5:05 p.m., the administrator said R2 had been transferred earlier with the ceiling lift and the sling "adjusted." The administrator said there was no concern with the lift hook up or sling size per R2. The administrator stated there had been no follow up with staff to verify if the appropriate sling had been used but said the care plan had been followed. During interview on 8/7/25 at 3:22 p.m., family member (FM)-A stated she was present when R2 slipped through the toileting sling. FM-A said she was not sure what happened but said R2 was about a foot above the bed and he slipped through and landed on his butt and back on the bed. FM-A said she thought the slings were one size fits all and said staff had used a larger sling before. R2 was present and said, "I fell out the bottom, that's why they brought me a new one," referring to the sling. R3's Admission Record indicated she admitted to the facility 4/16/23. R3's diagnosis included dementia, anxiety, right above knee amputation and chronic pain. R3's quarterly MDS dated 4/9/25, identified a memory problem and indicated she displayed physical, verbal and rejection of care behaviors 1-3 days during the assessment period. The MDS indicated R3 was dependent on staff for transfers. R3's Mobility/Lift Status Form dated 1/8/25, identified an amputation and indicated she could not bear weight and was not cooperative with transfers. The form identified the use of a ceiling lift. During observation on 8/6/25 at 4:13 p.m., NA-C and NA-D prepared to transfer R3. R3 was lying in bed and had a toileting sling underneath her. NA-C and NA-D switched the sling for a full body sling as directed in the care plan. NA-C stated the sling underneath R3 was not the correct sling. NA-D said the staff on the previous shift had used the wrong sling to transfer R3. During interview on 8/7/25 at 10:43 a.m., registered nurse (RN)-A stated slings were assessed on admission,	20830		

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20830	Continued from page 6 quarterly and with a change of condition. RN-A stated sling size and type were based on height and weight of the resident and said sling type was based on whether the resident was continent or not. RN-A said a toileting sling would not be used if there were physical limitations such as an amputation or if the resident was agitated or displayed behaviors and could go through the sling. RN-A said the toileting sling was appropriate for R1 even though R1's Lift form indicated she was unable to follow simple instructions and was not cooperative with transfers, because R1 still used the toilet. Facility Policy Sare Patient Handling dated 3/2020, indicated safe patient handling is a key component to providing employees a safe work environment, while providing high quality resident care. Specifically, mechanical lift equipment and/or other approved patient moving aides/devices should be used in all circumstances when liftin/moving residents except when manual assistance is deemed absolutely necessary. All resident care will be provided in a safe, appropriate and timely manner in accordance with the resident's plan of care. SUGGESTED METHOD OF CORRECTION: The administrator and director of nursing (DON) should review, revise, or create policies and procedures for assessing proper clings size and use for all residents utilizing mechanical lifts. Policies and procedures should include how often that assessment should be completed, sling wear and tear based on manufacturer's guidelines, wear individual slings will be kept for each resident and training procedures. All staff should be trained on new procedures. The results of those audits should be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	20830		