Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 19, 2023

Administrator
The Waterview Pines LLC
1201 8th Street South
Virginia, MN 55792

RE: CCN: 245283
Cycle Start Date: December 7, 2022

Dear Administrator:

On December 21, 2022, we notified you a remedy was imposed. On January 9, 2023 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 4, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 5, 2023 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of December 21, 2022, 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 7, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 19, 2023

Administrator
The Waterview Pines LLC
1201 8th Street South
Virginia, MN 55792

Re: Reinspection Results
Event ID: L3Y512

Dear Administrator:

On January 9, 2023 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 December 7, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
December 21, 2022

Administrator
The Waterview Pines LLC
1201 8th Street South
Virginia, MN 55792

RE: CCN: 245283
Cycle Start Date: December 7, 2023

Dear Administrator:

On December 7, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety 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.

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. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On December 7, 2023, the situation of immediate jeopardy to potential health and safety cited at F689 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 listed below to the CMS Region V Office for imposition: The CMS Region V Office 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 January 5, 2023.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 5, 2023, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 5, 2023, (42 CFR 488.417 (b)).

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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 7, 2022. This prohibition is not subject to appeal. 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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require 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 Sections 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 December 7, 2022. 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 plan of correction (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 "E" tag), i.e., the plan of correction should be directed to:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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, Licensing and Certification Program 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 June 7, 2023 (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 DENIAL OF PAYMENT

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) 565-9462

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	C 12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW PINES LLC	1201 8TH STREET SOUTH VIRGINIA, MN 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
F 000	INITIAL COMMENTS On 12/2/22, through 12/7/22, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be NOT IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety at F689. The IJ began on 11/22/22, at 4:10 p.m. when R1 had a fall from the ceiling lift. The fall resulted in R1 incurring a fractured hip. The administrators, the director of nursing (DON) and the nurse consultant were notified of the IJ on 12/6/22, at 3:36 p.m. The IJ was removed on 12/7/22, at 10:50 a.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 12/7/22. The following complaints were found to be SUBSTANTIATED: H52836477C (MN89088), with a deficiency cited at F609, F610, F689 H52836435C (MN88757) with no licensing orders issued. The following complaints were found to be UNSUBSTANTIATED: H52836088C (MN88603) H52836397C (MN88958) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/22/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §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	F 609		1/4/23

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F 609	Continued From page 2 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 ensure incidents of potential neglect were reported immediately, within two hours, to the State Agency (SA) for 1 of 3 residents (R1) reviewed for accidents. Findings include: R1's Diagnosis Report printed on 12/8/22, indicated R1's diagnoses included Alzheimer's disease, depression, osteoarthritis, weakness and pain. R1's care plan dated 8/6/19, indicated R1 was limited in ability to independently complete activities of daily living (ADLs) related to dementia. R1 required the total assistance of one staff for all ADLs. The care plan directed R1 transferred with the ceiling lift using a small full sit-on sling and the assistance of one staff. If the ceiling lift was unavailable, R1 was to be transferred with the floor mechanical lift using the small full body split-leg sling with the assistance of two staff. It was okay for R1's daughter to be the second assist. On 12/2/22, at 1:25 p.m. R1's family member (FM)-A reported to the surveyor on 11/22/22, R1 fell out of the ceiling lift during a transfer. R1 received a hip fracture from the fall. FM-A stated she was wondering if the fall had been reported because the only way to fall out of a ceiling lift was when a resident was not hooked up correctly. A facility incident report dated 11/22/22, indicated	F 609	F609 Reporting of Violations Immediate Corrective Action: Incident that occurred on 11/22/22 was reported to state agency on 12/2/22. Corrective Action as it applies to others: The Vulnerable Adult Policy was reviewed and remains current. All incidents have been reviewed that occurred in last 30 days to determine if incident was reported as appropriate. Clinical leaders and Administrator will be educated on need to report appropriate incidents to state agency in a timely manner per facility policy. Date of Compliance: 1/4/23 Recurrence will be prevented by: All incidents from last week will be reviewed to ensure that incident was reported as appropriate in a timely manner. 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: Administrator or Designee	

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F 609	Continued From page 3 on 11/22/22, at 4:10 p.m. R1 fell out of a transfer sling. R1 was unable to tell what happened. R1 had swelling to the top of her scalp. R1 was not sent to the hospital. R1 was being transferred from the bed to the recliner using a small full split-leg (sit-on) sling with the assistance of one staff. R1 fell through the sling and onto the floor. Immediate interventions were R1's sling was changed to a full sling. An x-ray report dated 11/23/22, indicated the reason for the x-ray was pain post-fall. The report indicated R1 had an acute comminuted (the bone was broken or crushed into three or more pieces) intertrochanter right femur fracture. During an interview on 12/5/22, at 10:46 a.m. with the administrator, the director of nursing (DON), the regional director of operations (DOO)-A and the nurse consultant (RN)-C, the DON stated immediately after the fall RN-A inspected R1's sling and found the sling used was the correct size. The DON stated R1 had a change in condition, did not have core strength and slid out of the sling. The DON stated RN-A had watched R1 transfer that morning by a different nursing assistant (NA) and R1 did fine in the sling. The sling was still hanging from the ceiling lift and was connected correctly. The DON stated it was not staff error, and that is why they did not report the incident to the SA. The facility's Abuse Prohibition Vulnerable Adult policy dated 4/11/22, directed the purpose of the policy implementation was to prevent injuries. The policy further directed avoidable accidents described as an accident of which occurred because the facility failed to evaluate or analyze the hazards and risks and eliminate them if	F 609		

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F 609	Continued From page 4 possible. If not possible, identify and implement measures to reduce the hazards or risks as much as possible. The policy further directed suspicion of neglect, exploitation, or misappropriation of resident property must be reported to the SA not later than 2 hours if the incident resulted in serious bodily injury.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §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 the overhead mechanical lift for 1 of 3 residents (R1) reviewed for accidents. Findings include: R1's Diagnosis Report printed on 12/8/22,	F 610	F610 Investigate Violations Immediate Corrective Action: Incident that occurred on 11/22/22 was reported to state agency on 12/2/22 and was further investigated. Corrective Action as it applies to others:	1/4/23

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F 610	Continued From page 5 indicated R1's diagnoses included Alzheimer's disease, depression, osteoarthritis, weakness and pain. R1's care plan dated 8/6/19, indicated R1 was limited in ability to independently complete activities of daily living (ADLs) related to dementia. R1 required the total assistance of one staff for all ADLs. The care plan directed R1 transferred with the ceiling lift using a small full sit-on sling and the assistance of one staff. If the ceiling lift was unavailable, R1 was to be transferred with the floor mechanical lift using the small full body split-leg sling with the assistance of two staff. It was okay for R1's daughter to be the second assist. On 12/2/22, at 1:25 p.m. R1's family member (FM)-A reported to the surveyor on 11/22/22, R1 fell out of the ceiling lift during a transfer. R1 received a hip fracture from the fall. FM-A stated she was wondering if the fall had been reported because the only way to fall out of a ceiling lift was when a resident was not hooked up correctly. A facility incident report dated 11/22/22, indicated on 11/22/22, at 4:10 p.m. R1 fell out of a transfer sling. R1 was unable to tell what happened. R1 had swelling to the top of her scalp. R1 was not sent to the hospital. R1 was being transferred from the bed to the recliner using a small full split-leg (sit-on) sling with the assistance of one staff. R1 fell through the sling and onto the floor. Immediate interventions were R1's sling was changed to a full sling. An x-ray report dated 11/23/22, indicated the reason for the x-ray was pain post-fall. The report indicated R1 had an acute comminuted (the bone	F 610	The Vulnerable Adult Policy was reviewed and remains current. All incidents have been reviewed that occurred in last 30 days to determine if incident was investigated thoroughly to determine if it needed to be reported to state agency. Clinical leaders and Administrator will be educated on need to investigate incidents thoroughly to determine if it needs to be reported to state agency. Date of Compliance: 1/4/23 Recurrence will be prevented by: All incidents from last week will be reviewed to ensure that incident was investigated thoroughly to determine if it needed to be reported to state agency. 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: Administrator or Designee	

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	245283	A. BUILDING _____ B. WING _____	C 12/07/2022

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F 610	Continued From page 6 was broken or crushed into three or more pieces) intertrochanter right femur fracture. During an interview on 12/5/22, at 10:46 a.m. with the administrator, the director of nursing (DON), the regional director of operations (DOO)-A and the nurse consultant (RN)-C, the DON stated immediately after the fall RN-A inspected R1's sling and found the sling used was the correct size. The DON stated R1 had a change in condition, did not have core strength and slid out of the sling. The DON stated RN-A had watched R1 transfer that morning by a different nursing assistant (NA) and R1 did fine in the sling. The sling was still hanging from the ceiling lift and was connected correctly. The DON stated it was not staff error, and there was no further investigation of what happened.. On 12/6/22, at 8:10 a.m. RN-A was interviewed again and stated R1 could have become limp and slid through the sling. RN-A stated therefore, R1's lift sling was changed to the full body sling with no opening. The facility's Abuse Prohibition Vulnerable Adult policy dated 4/11/22, directed the purpose of the policy implementation was to prevent injuries. The policy further directed avoidable accidents described as an accident of which occurred because the facility failed to evaluate or analyze the hazards and risks and eliminate them if possible. If not possible, identify and implement measures to reduce the hazards or risks as much as possible. The policy further directed the investigation team (including, but not limited to the administrator, DON, nurse manager, and social worker) would review all Incident Reports regarding residents including those that indicate	F 610		

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F 610	Continued From page 7 an injury of unknown origin, abuse, neglect, misappropriation of resident property, or involuntary seclusion no later than the next working day following the incident. Investigation would begin immediately.	F 610		
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 interview, and document review, the facility failed to provide a proper fitting transfer sling which resulted in a fall from the overhead mechanical lift for 1 of 3 residents (R1) reviewed for accidents. This resulted in an immediate jeopardy (IJ) for R1, when she slid through ceiling lift sling and fell and sustained a hip fracture and swelling to the top of her head. The immediate jeopardy (IJ) began on 11/22/22, at 4:10 p.m. when R1 had a fall from the ceiling lift. The fall resulted in R1 incurring a fractured hip and swelling to the top of her head. The administrator, the director of nursing (DON), the regional director of operations (DOO)-A and the nurse consultant (RN)-C were notified of the IJ on 12/6/22, at 3:36 p.m. The IJ was removed on 12/7/22, at 10:50 a.m. but non-compliance remained at the lower scope and severity of D, which indicated no actual harm with potential for	F 689	F689 Free from Accidents Immediate Corrective Action: R1□s MD was notified and resident/family decided not to send resident in for surgical intervention. Corrective Action as it applies to others: The Safe Lifting and Movement of Residents Policy was reviewed and remains current. All residents that utilize ceiling lifts were assessed to ensure that they are care planned for the appropriate ceiling lift sling as identified on the Sling Styles and Size Guide located in the Guldmann Lift Manual. All residents that require a need for a ceiling lift for transfers will be assessed by RN Manager or DON on admission to	1/4/23

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F 689	Continued From page 8 more than minimal harm that is not immediate jeopardy. Findings include: R1's Diagnosis Report printed on 12/8/22, indicated R1's diagnoses included Alzheimer's disease, depression, osteoarthritis, weakness and pain. R1's care plan dated 8/6/19, indicated R1 was limited in ability to independently complete activities of daily living (ADLs) related to dementia. R1 required the total assistance of one staff for all ADLs. The care plan directed R1 transferred with the ceiling lift using a small full sit-on sling and the assistance of one staff. If the ceiling lift was unavailable, R1 was to be transferred with the floor mechanical lift using the small full body split-leg sling with the assistance of two staff. It was okay for R1's daughter to be the second assist. On 12/2/22, at 1:25 p.m. R1's family member (FM)-A reported to the surveyor on 11/22/22, R1 fell out of the ceiling lift during a transfer. R1 received a hip fracture from the fall. FM-A stated she was wondering if the fall had been reported because the only way to fall out of a ceiling lift was when a resident was not hooked up correctly. A facility incident report dated 11/22/22, indicated on 11/22/22, at 4:10 p.m. R1 fell out of a transfer sling. R1 was unable to tell what happened. R1 had swelling to the top of her scalp. R1 was not sent to the hospital. R1 was being transferred from the bed to the recliner using a small full split-leg (sit-on) sling with the assistance of one staff. R1 fell through the sling and onto the floor.	F 689	facility or when a significant change is identified to ensure that they are care planned for the appropriate sling as identified in the Sling Styles and Size Guide located in the Guldmann Lift Manual. All nurses and CNAs were educated on the need to use the appropriate size/type of sling as identified on the resident□s care plan. If we are unable to get hold of staff to complete the training, those individuals were notified and removed from the schedule until the education can be completed. All nurses and CNAs had competencies redone with regards to ceiling lifts and their use along with how to utilize the slings. Starting 12/6/2022, all nurse and CNAs will complete the ceiling lift competency before their next working shift. If they have not completed the competency, they will not be allowed to work. Starting 12/6/2022, all newly hired nurse and CNAs will receive ceiling lift/sling education with a competency completed before their first working shift. Date of Compliance: 1/4/23 Recurrence will be prevented by: Audits on 3 residents that utilize ceiling lifts will be completed to ensure that staff are utilizing the correct size/type of sling identified on care plan and that they are utilizing the ceiling lift correctly during transfers. This will occur weekly x4 weeks then monthly times 2 months. The results	

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F 689	Continued From page 9 Immediate interventions were R1's sling was changed to a full sling. An x-ray report dated 11/23/22, indicated the reason for the x-ray was pain post-fall. The report indicated R1 had an acute comminuted (the bone was broken or crushed into three or more pieces) intertrochanter right femur fracture. During an interview on 12/5/22, at 10:46 a.m. with the administrator, DON, director of operations (COO)-A and RN-C, the DON stated immediately after the fall RN-A inspected R1's sling and found the sling used was the correct size. The DON stated R1 had a change in condition, did not have core strength and slid out of the sling. The DON stated RN-A had watched R1 transfer that morning by a different nursing assistant (NA) and R1 did fine in the sling. The sling was still hanging from the ceiling lift and was connected correctly. The DON stated it was not staff error. During an interview on 12/5/22, at 1:35 p.m. NA-A stated she was using the split-leg sling when transferring R1, and she connected the sling with the gray straps. NA-A stated she had never had a problem before. NA-A stated R1's care plan directed what size of sling to use. NA-A stated she did not look at the sling size and assumed it was the correct size. NA-A stated R1 had a shower and it was possible someone else brought the incorrect sling into R1's room. NA-A stated she was not sure but it was a possibility. NA-A stated R1 slid out of the bottom of the sling. NA-A tried to stop R1 from falling but it happened so fast. NA-A stated NA-B was in the room but did not help hook up the lift sling. NA-A stated R1 was transferred with the ceiling lift and one assist. NA-B was behind the chair to push the chair	F 689	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 689	Continued From page 10 under R1. NA-A stated NA-B did not have a chance to put chair under R1 because R1 fell so quickly. NA-A stated NA-B left the room to get RN-A, and RN-A was in R1's room within five minutes. NA-A stated the sling material was shiny and slippery, and R1's hands were on her chest. NA-A stated after the fall, leadership did not observe her providing transfers to any other resident. On 12/5/22, at 2:49 p.m. NA-A stated the only way a resident could slip out of a sling was if the sling was positioned incorrectly or if the sling was the wrong size. During an interview on 12/5/22, at 2:40 p.m. NA-B stated she was on the other side of R1's bed and about to leave the room. NA-B stated NA-A was transferring R1 with the ceiling lift as NA-B was going out the door. NA-B heard NA-A yell. When NA-B turned around R1 was falling from the lift sling and NA-A was trying to catch R1. The sling was the full body sling of which had an open bottom. NA-B stated the sling appeared to be hooked up properly. During an interview with RN-A on 12/5/22, at 2:20 p.m. RN-A stated upon entering R1's room after the fall from the ceiling lift, R1 was on the floor on her left side parallel to bed. A small sized split-leg sling was used during the fall, and was attached at all four points of the lift. RN-A assessed R1 who stated R1 winced with leg movement. After the fall from the lift, RN-A changed R1's sling from the small sized split-leg sling to the full-body sling. RN-A stated she checked the sling condition after the fall, and it was in good condition. RN-A further stated R1 sustained a right hip fracture from the fall.	F 689		

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F 689	Continued From page 11 On 12/6/22, at 8:10 a.m. RN-A was interviewed again and stated R1 could have become limp and slid through the sling. RN-A stated therefore, R1's lift sling was changed to the full body sling with no opening. On 12/6/22, 8:51 a.m. the DON and RN-C were interviewed. When questioned, the DON stated a resident could fall from a mechanical lift if the sling was not the appropriate size, or if the staff were not utilizing the lift or the sling correctly, or if the lift malfunctioned. The DON stated R1 was using a split-leg sling when she slid through the bottom of the sling. The straps were crossed and R1's legs should have gotten caught in the crossed straps. During an interview on 12/6/22, 10:15 a.m. with the Guldman's ceiling lift manufacturer chief operating officer (COO)-B, the COO-B stated residents do not fall from a lift sling if the sling is applied properly and the caregiver had been trained. If a resident slid out the bottom opening of a sling, the sling was not applied correctly. COO-B stated if a resident had poor core strength and slid out of a sling, then the sling was too big for the resident. The facility's Safe Lifting and Movement of Residents policy dated 7/17, directed the nursing staff and the rehabilitation staff would assess the residents need for transfer assistance on an ongoing basis. The resident would be assessed for preference, mobility, size, weight bearing ability, cognitive status, cooperation, and rehabilitation goals. The facility's Abuse Prohibition Vulnerable Adult	F 689		

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F 689	Continued From page 12 policy dated 4/11/22, included the purpose of the policy implementation was to prevent injuries. The policy further directed avoidable accidents described as an accident of which occurred because the facility failed to evaluate or analyze the hazards and risks and eliminate them if possible. If not possible, identify and implement measures to reduce the hazards or risks as much as possible. The IJ was removed on 12/7/22, at 10:50 a.m. when the facility verbally educated all nurses and nursing assistants on the need to use the appropriate size and type of sling as identified on the resident's care plan and competencies were redone in regard to ceiling lifts and use and on how to utilize the slings. Staff that did not receive the verbal training would be notified and removed from the schedule until education could be completed. Any newly hired nurses and nursing assistants would receive ceiling lift and sling education and competency completed before their first working shift. All residents that use ceiling lifts were assessed to ensure they were care planned for the appropriate ceiling lift sling as directed in the sling style and size guide in the manufactures lift manual. All residents that require a ceiling lift for transfers would be assessed by the RN managers or DON on admission or when a significant change was identified to ensure the resident was care planned for the appropriate sling. The Safe Lifting and Movement policy was reviewed and remained current.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 21, 2022

Administrator
The Waterview Pines LLC
1201 8th Street South
Virginia, MN 55792

Re: State Nursing Home Licensing Orders
Event ID: L3Y511

Dear Administrator:

The above facility was surveyed on December 2, 2022 through December 7, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 12/222, through 12/7/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT IN compliance with the MN State Licensure. The following complaints were found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H52836477C (MN89088), with licensing orders issued at 4658.0520 Subp 2.B., 626.557 Subd 3 H52836435C (MN88757) with no licensing orders issued. The following complaints were found to be UNSUBSTANTIATED: H52836088C (MN88603) H52836397C (MN88958) The 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 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 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 MN Requirement is not met as evidenced	2 830		1/4/23

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2 830	Continued From page 2 by: Based on interview, and document review, the facility failed to provide a proper fitting transfer sling which resulted in a fall from the overhead mechanical lift for 1 of 3 residents (R1) reviewed for accidents. This resulted in an immediate jeopardy (IJ) for R1, when she slid through ceiling lift sling and fell and sustained a hip fracture and swelling to the top of her head. The immediate jeopardy (IJ) began on 11/22/22, at 4:10 p.m. when R1 had a fall from the ceiling lift. The fall resulted in R1 incurring a fractured hip and swelling to the top of her head. The administrator, the director of nursing (DON), the regional director of operations (DOO)-A and the nurse consultant (RN)-C were notified of the IJ on 12/6/22, at 3:36 p.m. The IJ was removed on 12/7/22, at 10:50 a.m. but non-compliance remained at the lower scope and severity of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's Diagnosis Report printed on 12/8/22, indicated R1's diagnoses included Alzheimer's disease, depression, osteoarthritis, weakness and pain. R1's care plan dated 8/6/19, indicated R1 was limited in ability to independently complete activities of daily living (ADLs) related to dementia. R1 required the total assistance of one staff for all ADLs. The care plan directed R1 transferred with the ceiling lift using a small full sit-on sling and the assistance of one staff. If the ceiling lift was unavailable, R1 was to be transferred with the floor mechanical lift using the	2 830	Corrected	

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	00582	A. BUILDING: _____ B. WING _____	C 12/07/2022

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2 830	Continued From page 3 small full body split-leg sling with the assistance of two staff. It was okay for R1's daughter to be the second assist. On 12/2/22, at 1:25 p.m. R1's family member (FM)-A reported to the surveyor on 11/22/22, R1 fell out of the ceiling lift during a transfer. R1 received a hip fracture from the fall. FM-A stated she was wondering if the fall had been reported because the only way to fall out of a ceiling lift was when a resident was not hooked up correctly. A facility incident report dated 11/22/22, indicated on 11/22/22, at 4:10 p.m. R1 fell out of a transfer sling. R1 was unable to tell what happened. R1 had swelling to the top of her scalp. R1 was not sent to the hospital. R1 was being transferred from the bed to the recliner using a small full split-leg (sit-on) sling with the assistance of one staff. R1 fell through the sling and onto the floor. Immediate interventions were R1's sling was changed to a full sling. An x-ray report dated 11/23/22, indicated the reason for the x-ray was pain post-fall. The report indicated R1 had an acute comminuted (the bone was broken or crushed into three or more pieces) intertrochanter right femur fracture. During an interview on 12/5/22, at 10:46 a.m. with the administrator, DON, director of operations (COO)-A and RN-C, the DON stated immediately after the fall RN-A inspected R1's sling and found the sling used was the correct size. The DON stated R1 had a change in condition, did not have core strength and slid out of the sling. The DON stated RN-A had watched R1 transfer that morning by a different nursing assistant (NA) and R1 did fine in the sling. The sling was still hanging from the ceiling lift and was connected correctly.	2 830		

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2 830	Continued From page 4 The DON stated it was not staff error. During an interview on 12/5/22, at 1:35 p.m. NA-A stated she was using the split-leg sling when transferring R1, and she connected the sling with the gray straps. NA-A stated she had never had a problem before. NA-A stated R1's care plan directed what size of sling to use. NA-A stated she did not look at the sling size and assumed it was the correct size. NA-A stated R1 had a shower and it was possible someone else brought the incorrect sling into R1's room. NA-A stated she was not sure but it was a possibility. NA-A stated R1 slid out of the bottom of the sling. NA-A tried to stop R1 from falling but it happened so fast. NA-A stated NA-B was in the room but did not help hook up the lift sling. NA-A stated R1 was transferred with the ceiling lift and one assist. NA-B was behind the chair to push the chair under R1. NA-A stated NA-B did not have a chance to put chair under R1 because R1 fell so quickly. NA-A stated NA-B left the room to get RN-A, and RN-A was in R1's room within five minutes. NA-A stated the sling material was shiny and slippery, and R1's hands were on her chest. NA-A stated after the fall, leadership did not observe her providing transfers to any other resident. On 12/5/22, at 2:49 p.m. NA-A stated the only way a resident could slip out of a sling was if the sling was positioned incorrectly or if the sling was the wrong size. During an interview on 12/5/22, at 2:40 p.m. NA-B stated she was on the other side of R1's bed and about to leave the room. NA-B stated NA-A was transferring R1 with the ceiling lift as NA-B was going out the door. NA-B heard NA-A yell. When NA-B turned around R1 was falling from the lift	2 830		

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2 830	Continued From page 5 sling and NA-A was trying to catch R1. The sling was the full body sling of which had an open bottom. NA-B stated the sling appeared to be hooked up properly. During an interview with RN-A on 12/5/22, at 2:20 p.m. RN-A stated upon entering R1's room after the fall from the ceiling lift, R1 was on the floor on her left side parallel to bed. A small sized split-leg sling was used during the fall, and was attached at all four points of the lift. RN-A assessed R1 who stated R1 winced with leg movement. After the fall from the lift, RN-A changed R1's sling from the small sized split-leg sling to the full-body sling. RN-A stated she checked the sling condition after the fall, and it was in good condition. RN-A further stated R1 sustained a right hip fracture from the fall. On 12/6/22, at 8:10 a.m. RN-A was interviewed again and stated R1 could have become limp and slid through the sling. RN-A stated therefore, R1's lift sling was changed to the full body sling with no opening. On 12/6/22, 8:51 a.m. the DON and RN-C were interviewed. When questioned, the DON stated a resident could fall from a mechanical lift if the sling was not the appropriate size, or if the staff were not utilizing the lift or the sling correctly, or if the lift malfunctioned. The DON stated R1 was using a split-leg sling when she slid through the bottom of the sling. The straps were crossed and R1's legs should have gotten caught in the crossed straps. During an interview on 12/6/22, 10:15 a.m. with the Guldman's ceiling lift manufacturer chief operating officer (COO)-B, the COO-B stated residents do not fall from a lift sling if the sling is	2 830		

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2 830	Continued From page 6 applied properly and the caregiver had been trained. If a resident slid out the bottom opening of a sling, the sling was not applied correctly. COO-B stated if a resident had poor core strength and slid out of a sling, then the sling was too big for the resident. The facility's Safe Lifting and Movement of Residents policy dated 7/17, directed the nursing staff and the rehabilitation staff would assess the residents need for transfer assistance on an ongoing basis. The resident would be assessed for preference, mobility, size, weight bearing ability, cognitive status, cooperation, and rehabilitation goals. The facility's Abuse Prohibition Vulnerable Adult policy dated 4/11/22, included the purpose of the policy implementation was to prevent injuries. The policy further directed avoidable accidents described as an accident of which occurred because the facility failed to evaluate or analyze the hazards and risks and eliminate them if possible. If not possible, identify and implement measures to reduce the hazards or risks as much as possible. The IJ was removed on 12/7/22, at 10:50 a.m. when the facility verbally educated all nurses and nursing assistants on the need to use the appropriate size and type of sling as identified on the resident's care plan and competencies were redone in regard to ceiling lifts and use and on how to utilize the slings. Staff that did not receive the verbal training would be notified and removed from the schedule until education could be completed. Any newly hired nurses and nursing assistants would receive ceiling lift and sling education and competency completed before their first working shift. All residents that use	2 830		

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2 830	Continued From page 7 ceiling lifts were assessed to ensure they were care planned for the appropriate ceiling lift sling as directed in the sling style and size guide in the manufactures lift manual. All residents that require a ceiling lift for transfers would be assessed by the RN managers or DON on admission or when a significant change was identified to ensure the resident was care planned for the appropriate sling. The Safe Lifting and Movement policy was reviewed and remained current. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures related to staff transferring residents safely. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 830		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:	21980		1/4/23

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21980	Continued From page 8 (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21980	Corrected	

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21980	Continued From page 9 facility failed to ensure incidents of potential neglect were reported immediately, within two hours, to the State Agency (SA) for 1 of 3 residents (R1) reviewed for accidents. Findings include: R1's Diagnosis Report printed on 12/8/22, indicated R1's diagnoses included Alzheimer's disease, depression, osteoarthritis, weakness and pain. R1's care plan dated 8/6/19, indicated R1 was limited in ability to independently complete activities of daily living (ADLs) related to dementia. R1 required the total assistance of one staff for all ADLs. The care plan directed R1 transferred with the ceiling lift using a small full sit-on sling and the assistance of one staff. If the ceiling lift was unavailable, R1 was to be transferred with the floor mechanical lift using the small full body split-leg sling with the assistance of two staff. It was okay for R1's daughter to be the second assist. On 12/2/22, at 1:25 p.m. R1's family member (FM)-A reported to the surveyor on 11/22/22, R1 fell out of the ceiling lift during a transfer. R1 received a hip fracture from the fall. FM-A stated she was wondering if the fall had been reported because the only way to fall out of a ceiling lift was when a resident was not hooked up correctly. A facility incident report dated 11/22/22, indicated on 11/22/22, at 4:10 p.m. R1 fell out of a transfer sling. R1 was unable to tell what happened. R1 had swelling to the top of her scalp. R1 was not sent to the hospital. R1 was being transferred from the bed to the recliner using a small full split-leg (sit-on) sling with the assistance of one	21980		

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21980	Continued From page 10 staff. R1 fell through the sling and onto the floor. Immediate interventions were R1's sling was changed to a full sling. An x-ray report dated 11/23/22, indicated the reason for the x-ray was pain post-fall. The report indicated R1 had an acute comminuted (the bone was broken or crushed into three or more pieces) intertrochanter right femur fracture. During an interview on 12/5/22, at 10:46 a.m. with the administrator, the director of nursing (DON), the regional director of operations (DOO)-A and the nurse consultant (RN)-C, the DON stated immediately after the fall RN-A inspected R1's sling and found the sling used was the correct size. The DON stated R1 had a change in condition, did not have core strength and slid out of the sling. The DON stated RN-A had watched R1 transfer that morning by a different nursing assistant (NA) and R1 did fine in the sling. The sling was still hanging from the ceiling lift and was connected correctly. The DON stated it was not staff error, and that is why they did not report the incident to the SA. The facility's Abuse Prohibition Vulnerable Adult policy dated 4/11/22, directed the purpose of the policy implementation was to prevent injuries. The policy further directed avoidable accidents described as an accident of which occurred because the facility failed to evaluate or analyze the hazards and risks and eliminate them if possible. If not possible, identify and implement measures to reduce the hazards or risks as much as possible. The policy further directed suspicion of neglect, exploitation, or misappropriation of resident property must be reported to the SA not later than 2 hours if the incident resulted in serious bodily injury.	21980		

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21980	Continued From page 11 SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility could re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits should be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		