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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterview Woods LLC	601 Grant Avenue Eveleth, MN 55734

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49877 Based on observation, interview and document review, the facility failed to develop a comprehensive person-centered care plan based on the resident assessment which identified the type and size of sling required during transfers for 3 of 3 residents (R1, R3, R4) reviewed for mechanical lift use. Findings include: R1's fall incident report from 12/22/24 identified R1 was admitted to the facility on [DATE] with a primary diagnosis of chronic combined systolic and diastolic (congestive) heart failure (heart unable to pump enough blood to organs) and nonrheumatic aortic stenosis (narrowing of heart valve). R1's last brief interview for mental status (BIMS) was on 11/13/24 which showed moderate cognitive impairment. Incident report identified nursing assistant (NA)-A was transferring resident via ceiling lift from wheelchair to bed when R1 put her arms up which caused R1's upper body to slide through the sling. Licensed practical nurse (LPN)-B found R1 on the floor who was noted to have a bump that was bleeding on back of head. R1 was assessed by hospice nurse and did not require stitches. At the time of the fall, R1 was upgraded to a ceiling lift due to not standing in the stand aide and the correct sling and size were used during the transfer. Specific size and type of sling was not noted. Post fall, the director of nursing (DON) attempted education with the resident on proper body placement when in a sling. Staff was to now use a full body sling and will have 2 staff members presents during transfers. R1's progress note dated 12/22/24 at 8:37 p.m., identified resident upgraded to ceiling lift due to not standing in the stand aid. Correct type of sling and size was used during transfer. Resident was in ceiling lift being transferred into bed from wheelchair. Resident was being lifted out of wheelchair and resident lifted arm straight up and fell to the floor. R1's significant change Minimum Data Set (MDS) dated [DATE], identified R1 required Substantial/max assist with transfers. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan reviewed on 12/30/24, identified assist with movement in and in/out bed A2 (assist of two persons) nonmechanical lift. Use hoyer/ceiling lift as needed if resident is unable to stand in non-mechanical stand aide. Assist with transfers requires minimum assist from elevated recliner for sit/stand into nonmechanical stand aid for transfers. Care plan failed to identify the type and size of sling to be used with transfers. R3's admission MDS dated [DATE], identified diagnoses of chronic gout, coronary artery disease, hypertension, and arthritis. R3 was identified as dependent on staff for transfers. R3's care plan reviewed on 12/30/24, identified R3 required a ceiling / hoyer lift for transfers. Care plan failed to identify the sling type or size used during transfers. R4's quarterly MDS dated [DATE], identified diagnoses of seizures and arthritis. R4 was identified as dependent on staff for transfers. R4's care plan reviewed on 12/31/24, identified R4 required a ceiling / hoyer lift for transfers. Care plan failed to identify the sling type or size used during transfers. During interview on 12/30/24 at 1:13 p.m., nursing assistant (NA)-A confirmed being present during R1's fall on 12/22/24. NA-A was instructed to transfer R1 from wheelchair to bed. R1's care sheet identified R1 used a non-mechanical lift for transfers. Due to being unfamiliar with R1, NA-A confirmed R1's transfer status with another CNA and was instructed to use the ceiling lift due to R1 having weakness in the evenings. NA-A placed a half sling on R1 which was in R1's room, began to raise R1 from wheelchair, R1 began to flail, and slipped out of the sling. R1's lower body remained in the sling while R1's upper body fell to the ground. R1 hit her head on the ground during the fall and NA-A reported the fall to a nurse. During interview on 12/30/24 2:28 p.m., NA-B stated all residents who use a sling for transfers have their slings in their room. If uncertain about what sling size or type to use, would consult the care sheet. NA-B reviewed R1's care sheet and confirmed it listed the lift type but not sling size or type. During interview on 12/30/24 at 2:33 p.m., licensed practical nurse (LPN)-A stated if there was change in a resident's transfer status or if she upgraded the residents transfer status in an emergency, she would report this to nursing management and write a progress note. LPN-A would use the height / weight charts to select the correct sling. Each resident who uses a sling should have a sling in their room and the sling type should be listed on their care plan. During interview on 12/30/24 at 2:40 p.m., registered nurse (RN)-A confirmed R1's care plan and progress note from 12/22/24 did not list the type or size sling to use for transfers. RN-A was unsure if the sling type or size was listed in the medical record of any resident who used a sling. RN-A stated R1 was assessed by the DON post fall and was upgraded to a full body sling. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 12/30/24 at 3:11 p.m., DON stated any nursing staff can upgrade a resident from a non-mechanical to mechanical lift for safety. To select the correct sling, nursing staff are expected to use the manufacturers height and weight sling chart(s) posted at the nursing stations and should report any changes in sling/lift use to nursing management. The facility does not use a formal sling assessment form and the specific sling type and size used was not documented in the resident's care plan. The care plan includes lift type but not sling type. During observation on 12/31/24 from 8:43 a.m. to 11:01 a.m., resident's rooms who required lifts were audited for correct sling size based on size chart at nurse's station. The slings in resident rooms were correct based on manufacture chart guidelines. During interview on 12/31/24 at 4:40 p.m., the administrator expected all residents who require a sling for transfers are using the appropriate slings to ensure the safety of the residents and staff. Using an improper sling could result in anything from pinching and being uncomfortable to falls and injury. During interview on 12/31/24 at 4:41 p.m., DON indicated a comprehensive care plan was important as it directs resident care and plans to update the care plan(s) to include sling type and size for residents who use mechanical lifts.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49877 Based on observation, interview and document review, the facility failed to properly assess, care plan, and ensure the correct sling was used during transfers for 1 or 1 resident (R1) reviewed for mechanical lift transfers. The resident was transferred using a ceiling lift with a reported toileting sling (a sling which does not cover the buttocks) of unknown size, fell out of the sling during the transfer, and sustained a laceration to the back of head. The deficient practice was identified as an immediate jeopardy (IJ) situation, however, the provider had implemented corrective action prior to the investigation, therefore, the deficiency was issued as past non-compliance. The IJ began on 12/22/24 at 8:10 p.m., when R1 was transferred with a ceiling lift using a reported toileting sling of unknown size. R1 slipped out of the sling during the transfer which resulted in R1's head hitting the ground and sustaining a laceration to the back of the head. The administrator and director of nursing (DON) were informed of the IJ on 12/31/24 at 4:45 p.m. The facility implemented corrective action on 12/23/24, prior to the start of the survey, therefore, was past non-compliance. Findings include: R1's incident report from 12/22/24, identified R1 was admitted to the facility on [DATE], with a primary diagnosis of chronic combined systolic and diastolic (congestive) heart failure (heart unable to pump enough blood to organs) and nonrheumatic aortic stenosis (narrowing of heart valve). R1's last brief interview for mental status (BIMS) was on 11/13/24 which showed moderate cognitive impairment. Incident report described the accident as follows: NAR was transferring resident via ceiling lift from wheelchair to bed when resident put her arms up which caused her to slide through. LPN stated she walked in, and resident was on the floor. It was noted resident had a bump that was bleeding on back of head, vitals stable, A&O, eyes equal and reactive to light, pain level 5/10, pain medication given. Pressure bandage placed on the back of head. Hospice and family notified. R1's significant change Minimum Data Set (MDS) dated [DATE], identified R1 required substantial/max assist with transfers. R1's care plan reviewed on 12/30/24, identified assist with movement in and in/out bed A2 (assist of two persons) nonmechanical lift. Use [NAME]/ceiling lift as needed if resident is unable to stand in non-mechanical stand aide. Assist with transfers requires minimum assist from elevated recliner for sit/stand into nonmechanical stand aid for transfers. R1's progress note dated 12/22/24 at 8:34 p.m., identified resident has not been standing up for lift, she can't lift herself to stand. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's progress note dated 12/22/24 at 8:37 p.m., identified resident upgraded to ceiling lift due to not standing in the stand aid. Correct type of sling and size was used during transfer. Resident was in ceiling lift being transferred into bed from wheelchair. Resident was being lifted out of wheelchair and resident lifted arm straight up and fell to the floor. During interview on 12/30/24 at 12:38 p.m., R1 stated they dropped me. R1 explained during a recent transfer using a ceiling lift she slipped out of the sling and hit her head on the ground. R1 stated her head hurt after the fall but was unable to quantify her pain level. During interview on 12/30/24 at 1:13 p.m., nursing assistant (NA)-A confirmed being present during R1's fall on 12/22/24. This was NA-A's second day working at the facility and first time working with R1. NA-A was instructed to transfer R1 from wheelchair to bed. R1's care sheet identified R1 used a non-mechanical lift for transfers. Due to being unfamiliar with R1, NA-A confirmed R1's transfer status with another CNA and was instructed to use the ceiling lift due to R1 having weakness in the evenings. NA-A was informed R1 tends to flail during transfers with ceiling lift. NA-A placed a half sling on R1 which was in R1's room, began to raise R1 from wheelchair, R1 began to flail, and slipped out of the sling. R1's lower body remained in the sling while R1's upper body fell to the ground. R1 hit her head on the ground during the fall and NA-A reported the fall to a nurse. During interview on 12/30/24 2:28 p.m., NA-B stated all residents who use a sling for transfers have their slings in their room. If uncertain about what sling size or type to use, would consult the care sheet. During interview on 12/30/24 at 2:33 p.m., licensed practical nurse (LPN)-A stated if there was change in a resident's transfer status, she would report this to nursing management. If nursing management was not available and it was a safety issue she would upgrade the resident's lift/sling type. She would select the correct sling by consulting the sling size chart(s) at the nursing station, write a progress note, and report the change to nursing management. Each resident who uses a sling should have a sling in their room. During interview on 12/30/24 at 2:40 p.m., registered nurse (RN)-A confirmed R1's care plan and progress note from 12/22/24 did not list the type or size sling to use for transfers. RN-A was unsure if the sling type or size was listed in the medical record of any resident who used a sling. RN-A stated R1 was assessed by the director of nursing (DON) post fall and was upgraded to a full body sling. During interview on 12/30/24 at 3:11 p.m., DON stated any nursing staff can upgrade a resident from a non-mechanical to mechanical lift for safety. To select the correct sling, nursing staff are expected to use the manufacturers height and weight sling chart(s) posted at the nursing stations and should report any changes in sling/lift use to nursing management. The facility does not use a formal sling assessment form and the specific sling type and size used was not documented in the resident's medical record. The appropriate sling should always be in the resident's room and if staff are unaware what size/type of sling to use they should consult with another staff member and/or the manufactures height and weight chart(s). DON stated R1 had not been using the ceiling lift prior to the fall on 12/22/24 and the use of a sling for R1 should be signed off by a register nurse prior to its continued use. DON reported on 12/23/24 she completed a sling assessment on R1 and determined due to R1's inability to keep arms on the outside of a toileting sling, R1 required a full body sling and the assist of 2 during transfers with the ceiling lift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 12/31/24 at 8:25 a.m., trained medical aid (TMA)-A stated during an emergency all nursing staff can implement the use of a sling, but only half back slings. An assessment by an RN or physical therapy was needed for a full sling. To implement a sling, the sling charts need to be consulted to determine the correct size and this should be reported to nursing management who document the sling. Any available staff member can obtain a sling from the sling room. During interview and observation on 12/31/24 at 8:58 a.m., NA-C identified as being pool staff and stated slings were always in the resident's room and only facility staff were able to obtain slings. NA-C located the sling in R4's room and identified it was a Guldman, size medium toileting sling. While R4 was in wheelchair, NA-C proceeded to place the back of the sling across R4's back and leg straps under R4's legs. NA-C crossed the leg stapes, moved the ceiling lift towards R4, properly connected the upper and lower body sling strap loops to the ceiling lift. NA-C instructed R4 to keep arms outside of and hold on to sling. NA-C slowly raised R4 from wheelchair and transferred to bed making sure R4's body was in proper alignment prior to lowering the lift. When R4 was fully lowered onto the bed, NA-C removed the sling loops from the lift, moved the sling away from R4's lower body, and pushed the lift a safe distance away from R4 before proceeding with cares. R4 reviewed and determined to be using the proper sling size based on manufactures guidelines. During interview on 12/31/24 at 11:13 a.m., LPN-A confirmed being the nurse who responded to R1's fall on 12/22/24. Prior to the fall, LPN-A had made the determination to upgrade R1 from a non-mechanical lift to the ceiling lift due to weakness. LPN-A did not select the sling size/type and used the sling that was already in R1's room, which was described as not a full body sling of unknown size. LPN-A stated R1 has been having intermittent weakness in the evening and has been using the ceiling lift for a while. As a result of the fall, R1 sustained a laceration to the back of her head which required a pressure bandage and per hospice nurse evaluation did not require stitches. LPN-A stated when selecting what sling to use, she does not take measurements of the resident or reference any manufacturers chart(s) to determine what sling size to use. Sling was selected based on how it fits around the residents back. During follow up interview on 12/31/24 at 11:52 a.m., DON was unaware R1 was using a ceiling lift prior to 12/22/24 and would expect this change to be reported. DON stated there was no way to determine when R1 began to use the ceiling lift unless a progress note was made as expected, but this does not always happen. In response to the fall, the DON stated on 12/23/24, the DON and administration re-assessed all residents who use a sling to ensure the correct size and type was being used. Aside from R1, no change in sling type/size was needed. All direct care staff were required to complete mechanical stands competency prior to the start of next shift. During observation on 12/31/24 from 8:43 a.m. to 11:01 a.m., residents rooms who were required lifts were audited for correct sling size based on size chart at nurses station. The slings in resident rooms were correct based on manufacture chart guidelines. During document review on 12/31/24, signed copies of direct care staff mechanical stands competencies dated 12/23/24 to 12/31/24, outlined how to utilize mechanical stands, including how to apply slings, per manufacturer guidelines and facility policy and procedure. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 12/31/24 at 4:40 p.m., the administrator expected all residents who require a sling for transfers are using the appropriate slings to ensure the safety of the residents and staff. Using an improper sling could result in anything from pinching and being uncomfortable to falls and injury. A policy for mechanical lift and sling use was requested, but not provided. Facility identified they do not have a specific policy but follow manufacturers guidelines. The facility implemented corrective action to prevent recurrence by 12/23/24, when the facility implemented a systemic plan that included the following actions: On 12/23/24 DON completed a sling assessment on R1 and determined a full body sling with the assist of 2 was required during ceiling lift transfers. On 12/23/24, all residents who use mechanical lifts were re-assessed for the correct sling size and type. Starting on 12/23/24 all direct care staff were required to complete a mechanical stand use competency prior to the start of their next shift.