

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 The Waterview Pines LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 8th Street South Virginia, MN 55792	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>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 ceiling 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. 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.</p>

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
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], identified severe cognitive impairment and indicated she displayed no behaviors. The care plan indicated 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 ceiling 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. 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 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</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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 ceiling 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 to 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 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. 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