Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7013 3020 0001 8869 0985

May 10, 2016

Mr. Thomas Goeritz, Administrator
Valley View Manor HCC
200 East Ninth Avenue
Lamberton, MN 56152

Subject: Valley View Manor Hcc - IDR
Provider # 245378
Project # S4302

Dear Mr. Goeritz:

This is in response to your letter of January 29, 2016, in regard to your request of an informal dispute resolution (IDR) for the federal deficiency at tag F157 §483.10(b)(11) issued pursuant to the survey event ZNOX11, completed on December 31, 2015.

The information presented with your letter, the CMS 2567 dated December 31, 2015, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F157 (G) 42 CFR § §483.10(b)(11) -- Notification of changes. A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.12(a).
(ii) The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is--
(A) A change in room or roommate assignment as specified in §483.15(e)(2); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.
(iii) The facility must record and periodically update the address and phone number of the

resident's legal representative or interested family member.

The facility indicated contacting the physician for R46 via fax for "serious resident conditions" was a "traditional standard of practice authorized by attending physician." The nurse did notify the physician via fax which fulfilled her obligation of physician notification for R46.

Review of the 2567, provider information, surveyor's notes and interviews identified the following:

R46 had an upset stomach which started on 9/25/16, at 8:30 a.m. and he continued to have an upset stomach and at 1:39 p.m. progressed to projectile vomiting, with an emesis that had a "colicky" odor and a temperature of 99 degrees Fahrenheit. A facsimile was sent to the physician on 9/25/15, at 6:00 p.m. with an update of R46's condition. R46's condition continued to worsen and on 9/26/15, at 1:56 a.m. with a distended abdomen, diminished bowel sounds, and emesis which looked like bowel movement (BM). He had an emesis at 4:48 a.m. which looked like soft formed/loose BM. R46 was cool, and clammy, elevated temperature and continued to "wretch." At 9:57 a.m. R46 had additional emesis, with green liquid with pieces of BM. The physician was contacted at this time and R46 was sent and admitted to the hospital, for a small bowel obstruction. The emergency note indicated R46's abdomen was firm, distended, and tender with no appreciable bowel sounds and underwent surgery for a small bowel obstruction.

There was no follow up by the physician from the fax the facility sent to the physician on 9/25/15, (Friday) at 6:05 p.m. per Valley View Manor time stamp on the facsimile. The physician office closed at 4:30 p.m., and the fax was sent at 6:00 p.m. There was a note printed on facsimile under Response by Physician that identified, "Please do NOT fax in regard to situations that need attn. [attention] that day. This was sent to Dr Dahami- today 9/28/15 [Monday]. Please review the faxing for response procedure, Thx [thanks]." The physician responded on 9/28/16 which read, "Noting telephone order to transfer to ER on 9/26/15."

R46 had multiple emesis on 9/25/15, which progressed on 9/26/15 at 1:56 a.m. with an emesis that looked like BM, had a distended abdomen and diminished bowel sounds. R46's condition continued to worsen, and had additional emesis on 9/26/15, at 4:48 a.m. which looked like formed/loose BM. Despite R46's significant change in condition at 1:56 a.m. and 4:48 p.m. the facility had not contacted the physician regarding these changes until 9:57 a.m. on 9/26/15. After the physician was contacted at 9:57 a.m. R46 was immediately transferred to the hospital and admitted for a bowel obstruction and surgery. The facility did not contact the physician timely when R46 exhibited significant symptoms that needed to alter the plan of treatment for R46, which resulted in actual harm for R46.

As a result of this IDR, the deficiency issued at F157 G level for R46 is at the correct tag and scope and severity.

The facility indicated R21's physician was aware of R21's high blood sugar spikes, and knew R21 was a brittle diabetic in nature. There were no episodes of high blood sugar readings that were unknown by the attending physician, so all readings were covered.

Review of the 2567, provider information, surveyor's notes and interviews identified the following:

R21's had multiple high blood sugar reading from 12/1 to 12/29/15, which 44 of these were above 400 mg/dl, and 25 were greater than 430 mg/dl.

R21 was seen on 12/8/15, for routine nursing home rounds for her 30 day visit. The note identified R21 had higher blood sugars in the low 200's and sometimes 500, with no recent low blood sugars which she was hospitalized. She has a long standing history of R21's blood sugar, which they have been following for the past 2 years and is a brittle diabetic. The plan was to continue with the same insulin dosage and to set her up with faxing her blood sugars to the diabetic educator weekly to get better control of her blood sugars. The note identified, they do contact the physician for R21's blood sugars, and faxing R21's blood sugars to the diabetic educator weekly.

Review of the information identified the diabetic educator was receiving R21's blood sugars on a weekly basis, and forwarded them to the physician as identified by the physician's note on 12/8/15.

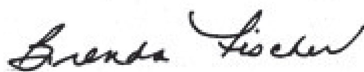
This in not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies for R21.

The removal of this example does not negate the findings in the remainder of the deficiency. The deficiency remains valid at a scope and severity of G, actual harm. A new 2567 will be sent to the facility to identify the removal of this example for R21.

This concludes the Minnesota Department of Health informal dispute resolution process.

Please note it is your responsibility to share the information contained in this letter and the results of this review with the President of your facility's Governing Body.

Sincerely,



Brenda Fischer, RN Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 320-223-7338 Fax: 320-223-7348

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Licensing and Certification File
Kathy Serie, Mankato District Office Unit Supervisor

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/10/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 Revised 2567 as a result of an Informal Dispute Resolution, see tag F157. 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 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 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157		2/8/16

REVISED

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 01/29/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 157	Continued From page 1	F 157		

F 157 — Summary Statement of Deficiencies

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to notify the physician in a timely manner for 1 of 4 residents (R46) reviewed for hospitalization who experienced significant changes in condition requiring medical treatment. This resulted in actual harm for R46, who experienced prolonged discomfort, dehydration and vomiting, related to delayed physician notification and subsequent transfer to an inpatient facility for a small bowel obstruction.

Findings include:

R46's discharge orders to the nursing home dated 9/17/15, identified a discharge condition of improving with orders for physical and occupational therapy.

R46's physician's progress notes, dated 9/18/15 indicated diagnoses of spinal stenosis of the lumbar region, sepsis, and urinary tract infection. The physician's progress note also identified a history of diverticulitis of the colon.

F 157 — Provider's Plan of Correction

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:

1. Resident #21 s physician has been updated on a regular basis on the changes in her condition and overall status. Resident #46 is deceased.
2. All resident s were reviewed for any change in condition and need to notify the physician per phone call. All resident orders for insulin were reviewed and corrected where orders to call the physician for high glucose readings. Our standing orders were updated per

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 157

Continued From page 2

R46's admission Minimum Data Set (MDS), dated 9/24/15 identified a Brief Interview for Mental Status score of 13/15 (cognitively intact). No care area assessments were completed with the MDS.

R46's care plan, dated 9/30/15 identified no cognitive impairments and that R46 desired to return to the community.

R46's September 2015 medication sheets revealed R46 had received Maalox (an antacid) 30 cubic centimeters (cc)'s on 9/25/15 a total of four times on that date, as well as one dose at 2:00 a.m. on 9/26/15. Notations documented by licensed practical nurse (LPN)-A on the back of the medication administration record for a dose administered on 9/25/15, at 2:00 a.m. indicated the medication had been given for stomach upset since supper. No follow up assessment for effectiveness was completed. A subsequent entry dated 9/26/15, at 2:00 am. indicated R46 had received another dose of Maalox for an upset stomach and emesis; the follow up result was listed as had another emesis at 4 a.m. None of the other doses administered had follow up results documented.

A nursing progress note written by LPN-F on 9/25/15 at 8:30 a.m., indicated R46 had hiccups and complaints of not feeling well. The notes indicated R46 had been given Maalox 30 cc's along with Thorazine and had begun retching after his morning medications. In addition, R46 had experienced a large projectile emesis all over the bed and himself, and had refused to eat anything for breakfast, stating he had consumed orange juice that had all come up.

F 157

recommendation of our medical director to notify the physician if two Blood Glucose results are <70 or >400 in a 24 hour period.

3. Education to licensed staff will be completed by 2-3-16 on ensuring that physicians are notified in a timely manner concerning any resident change in condition and that physician orders are obtained for elevated glucose levels, including orders to call the physician when there is two blood Glucose results <70 or >400 in a 24 hour period.

4. When residents present with a change of condition nurses will call the physician immediately (within a timely manner) and notify the Director of Nursing instead of using fax. Physician orders are obtained for elevated glucose levels, including orders to call the physician when there is two blood glucose results <70 or >400 in a 24 hour period.

5. The DNS or designee will complete 2 audits weekly for 4 weeks and weekly for 2 months to ensure that the facilities guide line is being followed correctly.

6. The data collected will be reviewed/discussed at the quarterly QA&A meeting. At this time the QA&A committee will make the decision/recommendation regarding any follow-up studies.

The DNS will be responsible for this POC.
Completion Date: 2-8-16

Valley View Manor Plans to IDR F157.

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 157	Continued From page 3 A nursing progress note documented by LPN-F on 9/25/15, at 1:39 p.m. indicated R46 had a large emesis, and that the resident had stated he was not feeling well. The notes indicated his hiccups had subsided for a while but had then started again. Documentation indicated R46 had received Maalox and Thorazine (an antipsychotic medication used for antiemetic properties) with another small emesis afterward. The emesis was documented as having had food particles present and was described as having a colicky odor. R46's temperature was documented as having been elevated at 99.0 degrees Fahrenheit (F). A nursing progress note dated 9/25/15, at [illegible]:00 p.m. per LPN-F indicated R46 had stayed in bed most of the evening. The note indicated R46's hiccups were better over the early evening hours but that R46 had been stated his tummy still didn't feel right and that whenever he moved he began to gag. R46 had eaten Jell-O for supper and had sips of water. Additionally, the documentation indicated a fax (facsimile) had been sent to medical doctor (MD)-A with an update on R46's condition including that R46 had an elevated temperature at 99.5 degrees F and complained of feeling chilly. A nursing progress note dated 9/25/15, at 11:05 p.m. per LPN-F indicated R46 had not been feeling well, and had been having brown colored emesis twice on the afternoon shift which did not appear to have a feces odor. Maalox 30 cc's had been given to help with hiccups and R46's vitamins had been held due to emesis. A nursing progress note by LPN-A, dated 9/26/15, at 1:56 a.m. indicated R46's abdomen was distended, his bowel sounds were difficult to hear	F 157		

REVISED

F 157 Continued From page 4 F 157

and he had been having emesis which looked like BM. R46's temp was noted to be slightly elevated at 99.1 degrees F.

A nursing progress note written by LPN-A on 9/26/15, at 4:48 a.m. indicated R46 had 100 cc's of emesis, like soft formed/loose BM (bowel movement) with no odor. The note further indicated R46 was cool and clammy, with a slightly elevated temperature at 99.1 degrees F. R46 had a wastebasket beside him, and continued to wretch.

A nursing progress note entered by LPN-B, dated 9/26/15, at 9:57 a.m. indicated R46 had two further emesis of greenish liquid thick with pieces of BM looking in it. In addition, the note indicated an acute care hospital had been called and an order was received to transfer R46 to their emergency room (ER) via ambulance. The note indicated R46's daughter was updated and had agreed to meet him at the hospital. R46 left the facility at 8:45 a.m.

REVISED

A faxed physician's order dated 9/26/15 was present in R46's record and verified the physician order to transfer per ambulance to the acute care hospital.

An additional nursing progress note dated 9/26/15, at 2:06 p.m. indicated R46 had been admitted to the acute care hospital with a diagnoses of bowel obstruction, and would need surgery.

A faxed physician's order sent on 9/25/15, at 6:05 p.m. from the facility to R46's primary physician identified that R46 had emesis since 8:30 a.m., experienced several rounds of hiccups

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 157	Continued From page 5	F 157		

Continued From page 5

throughout the day and had been unable to eat or drink. R46 complained of feeling weak. The fax had not been signed off until on 9/28/15, three days later, when the nurse practitioner (NP)-A responded with a statement including, "Noting telephone order to transfer to ER on 9/26/15. Please do NOT fax in regard to situations that need attn [attention] that day. This will be sent to [physician] - today 9/28/15. Please review the faxing for response procedure. Thx [Thanks]."

The ER progress note dated 9/26/15, at 10:36 a.m. was reviewed. The ER note indicated R46 had appeared distressed when examined, had been uncomfortable, and had dry oral mucous with dried brown material on the tongue and lips. The ER note further indicated R46's abdomen was firm and diffusely distended, mildly tender with no appreciable bowel sounds. In addition, 1800 milliliters (ml) of brown liquid had been drained from R46's stomach after the insertion of a nasogastric tube. R46 had received 2000 ml of normal saline intravenous for hydration. The ER physician's note indicated R46 had appeared quite dehydrated and verified the admitting diagnoses of small bowel obstruction and severe dehydration.

The ER registered nurse's assessment dated 9/26/15, at 11:17 a.m. indicated: R46 had stated he'd been vomiting for the last two days and his emesis was now brown like stool. R46 had vomited three times in the ambulance enroute to the ER and the vomit was described as dark brown liquid running out of his mouth. R46's abdomen was very firm, with no bowel sounds and the abdomen was distended. R46 complained of abdominal pain but was unable to rate the pain. R46 had his stomach drained via a

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	**12/31/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 157	Continued From page 6	F 157		

nasogastric tube for ten minutes with 1400 mL of fluid output after which R46 stated he felt much better. R46 was alert and "states we should do what ever we have to do. Is comfortable now."

The hospital discharge summary dated 10/5/15, indicated R46 had undergone abdominal surgery to correct the small bowel obstruction, and had developed subsequent cardiac and anticoagulation issues as well as post-operative ileus (disruption in normal bowel motility) after the surgery. The ileus resolved with the replacement of a nasogastric tube; however, comfort cares were initiated and R46 passed away on 10/5/15.

During interview on 12/29/15, at 3:07 p.m. the director of nursing (DON) verified she would have expected staff to contact the on-call doctor immediately with the urgent clinical issues, especially when the resident was vomiting BM-type material and not feeling better.

During interview on 12/29/15, at 3:32 p.m. the nursing home's health information coordinator/nursing scheduler (HIM) stated LPN-B was not well and was currently in a hospital intensive care unit, unavailable for interview. The HIM verified LPN-F had been a pool nursing staff.

During interview on 12/29/15, at 3:45 p.m. the acting administrator, who had been the DON at the time of the incident stated she'd thought R46's family had indicated he was admitted to the hospital with a bowel obstruction, but that it had later been found to be a narrowed bowel. The administrator was unable to recall specifics regarding R46's episode of illness; however, stated she would have expected staff to

REVISED

(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 157	Continued From page 7 contact/call the on-call and/or primary physician directly with concerns that were urgent. The administrator stated she would have expected the staff to check the vital signs, bowel movement status, appetite and fever status while conducting a physical assessment. The administrator stated she thought LPN-A was a good nurse and trusted her judgment. She further verified LPN-A worked every Thursday night shift. When LPN-A was interviewed about the incident on 12/29/15 at 4:02 p.m., LPN-A stated she'd received report from the evening nurse (LPN-F) on 9/25/15, regarding R46's emesis, but had been unaware a fax had been sent. LPN-A stated she'd worked with R46 at least one time prior and was aware R46's vomiting and complaints of not feeling well was new for R46. She was aware R46 had thrown up and had not been eating well, and had subsequently administered Maalox during the night. LPN-A thought the Maalox had helped somewhat the first time she administered it (around 2:00 a.m.). LPN-A verified R46 had emesis of what looked like stool but there was no odor. She verified his abdomen had also seemed a little distended. LPN-A was unaware whether R46 had complained of pain. LPN-A said R46 subsequently vomited and it looked more like BM later in her shift (around 5:00 a.m.) at which time she'd become concerned that he may have something wrong with his small bowel. LPN-A said she'd proceeded to fill out all the transfer paperwork for a hospital discharge; however, did not call the RN on call nor notify the physician of her concern. LPN-A indicated she had passed along the paperwork and her concern to the day nurse, LPN-B, who arrived on duty at 6:00 a.m. on 9/26/25. LPN-A stated she'd told LPN-B to do	F 157		

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 157		F 157		

Continued From page 8

an assessment to follow up on R46's condition. During the interview, LPN-A stated she thought there had been a history of small bowel concerns she had noted when filling out the paperwork to pass along to the day shift personnel.

During a follow up interview on 12/30/15, at 9:12 a.m. the administrator stated LPN-A should have notified the physician sooner about R46's symptoms, and that she had not been aware there had been a delay in his nursing care and physician notification of his condition.

During interview on 12/30/15, at 2:11 p.m. the medical director was interviewed and stated she would have expected nursing staff to call when they filled out the paperwork to transfer R46 to the hospital. The medical director stated although R46 may have subsequently expired anyway, prompt medical care would have made him comfortable. The medical director stated the effect of delayed medical care/interventions related to R46's medical outcome was difficult to state since she was not his usual physician.

During interview on 12/31/15, at 9:27 a.m. medical doctor (MD)-A (R46's usual physician) stated he would have expected staff to have called the clinic and/or the on-call physician when R46 began vomiting stool-like material. MD-A stated faxing medical staff at the clinic at 6:00 p.m. was inappropriate as the fax machine was not attended at that time of day. MD-A stated he'd been concerned about the potential for ischemic bowel when R46 arrived at the hospital, due to the delay in receipt of medical attention after his symptoms began. MD-A stated R46 had made some "depressed" comments prior to the hospital transfer on 9/26/15, but those comments

REVISED

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/10/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	**12/31/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 157	Continued From page 9 were a "sidebar" and were not relevant to this issue. MD-A confirmed R46 would have been more comfortable if he had been examined sooner in the ER. MD-A stated, "when you are vomiting brown stuff, it is probably a good idea if you are seen." The facility's policy entitled Change in Condition SBAR last revised 3/15, indicated immediate notification of the physician was required for any symptom, sign or apparent discomfort that was sudden in onset, a marked change (i.e. more severe) in relation to usual signs and symptoms and was unrelieved by measures already prescribed. The policy further indicated in a section related to abdominal distension that immediate notification of the physician was required when there was rapid onset, or presence of marked tenderness, fever, vomiting or GI (gastrointestinal) bleeding.	F 157		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 167	The preparation of the following plan of	2/8/16

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 167	Continued From page 10 review the facility failed to ensure the most current survey results were posted in an area readily accessible to residents, families and visitors. This had the potential to affect all 40 residents currently residing in the facility. Findings include: During the initial tour of the facility with the director of nursing (DON) on 12/28/15, at 12:00 p.m., observations revealed the current federal and state survey results were not available to residents, families or visitors. The DON indicated the results are usually posted on the bulletin board near the north and south nurses stations, but confirmed they were not in that location. After 15 minutes of looking for the survey results, the DON found them to be in a 3- ring binder placed behind the south nurses station in the resident chart stand. The binder which included the survey results was not visible nor easily accessible to the residents, families or visitors. The DON confirmed this.	F 167	correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Posting the most current survey results in an area readily accessible to residents, families and visitors. 2. All residents, families and visitors will have access to the most current survey results. 3. Education will be completed by 2-5-16 at an all staff meeting in regards to posting the most current survey results and the importance of the location designated for the current survey results. 4. The Administrator or designee will ensure that the most current survey results are posted in the designated location. The Administrator or designee will do audits 5 times per week for 1 month, then audits three times a week for 2 months to ensure that the facilities plan of correction is being followed. 5. The data collected will be reviewed/discussed at the quarterly QA&A meeting. At that time the QA&A committee will make the decision/recommendation regarding any follow-up studies. The Administrator will be responsible for this POC.	

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 167	Continued From page 11	F 167	Completion date: 2-8-16	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the safe practice of self-administration for 1 of 2 residents (R6) who were observed self administering a nebulizer treatment. Findings include: R6's physician orders dated 12/8/15, included Ipratropium-Albuterol solution 0.5-2.5 (3) milligrams/3 milliliters, 1 vial inhale orally three times a day for shortness of breath, every 6 hours while awake. R6's annual Minimum Data Set (MDS) dated 10/9/15, indicated R6 had severe cognitive impairment. Review of R6's care plan dated 10/12/15 included a risk for alteration in respiratory status related to (r/t) diagnoses of emphysema/COPD (chronic obstructive pulmonary disease) with recurrent acute episode. History of (h/o) pneumonia, and h/o bronchospasms (sudden constriction of the muscles in the walls of the bronchioles causing difficulty breathing). The care plan further	F 176	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Resident # 6 was transferred to another facility on 1-25-16. 2. All residents for whom nebulizer treatments are ordered have been reviewed to ensure that nursing staff are remaining with them during their breathing treatments. 3. Education will be completed by 2-3-16 for all Licensed Nursing staff on administration of nebulizer treatments that include remaining with the resident during the entire nebulizer treatment. A clinical Competency by Licensed Nursing Staff will be completed. Each nurse, when	2/8/16

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	**12/31/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 176	Continued From page 12 identified a behavior problem r/t dementia which included routinely refusing neb (nebulizer) treatments. Further review of the medical record did not include evidence of an assessment related to R6's ability to self-administer medications. On 12/29/15, at 2:39 p.m. two surveyors observed R6 sitting on the edge of his bed wearing a nebulizer mask with machine running and medication noted in the nebulizer solution receptacle. R6 was alone in the room with no staff present within visualization of the resident. On 12/29/15, at approximately 2:50 p.m. licensed practical nurse (LPN)-D was observed in R6's room. R6 was sitting on the edge of bed though no longer had the nebulizer mask on nor was the machine running. When interviewed on 12/31/15, at 9:09 a.m. the director of nursing (DON) confirmed R6 did not have an assessment to self administer medications; the medication nurse was expected to remain with the resident throughout a nebulizer treatment. The DON further confirmed C6 had a history of being non-compliant with administration of nebulizer treatments. The facility policy/procedure titled, Nebulizers included: "10. Monitor the resident throughout the treatment."	F 176	signing for completion of the nebulizer treatment for each resident receiving one in the MAR, will be trained that by signing, they not only verify that they performed the nebulizer treatment procedure for the resident but that their signature also verifies that they remained with the resident during the course of the nebulizer treatment as a necessary part of the procedure. 4. The DNS or designee will complete two audits per week for four weeks then weekly for two months to ensure compliance. 5. The data collected will be reviewed/discussed at quarterly QA&A meeting. At this time the QA&A committee will make the decision/recommendation regarding any follow-up studies. The DNS is responsible for the POC. Completion Date: 2-8-16	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with	F 248		2/8/16

REVISED

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/10/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 248	Continued From page 13 the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide activities for 2 of 3 (R6, R23) residents reviewed for activities. Findings include: R6 R6 was admitted to the facility on [illegible]/14, with diagnoses including dementia without behavioral disturbance, cognitive communication deficit, chronic obstructive pulmonary disease (COPD) muscle weakness and difficulty walking per the facility diagnosis report. R6's annual Minimum Data Set (MDS) assessment dated 10/9/15, indicated severely impaired cognition with daily wandering that significantly intruded on the privacy of others, physical behavior towards others 1-3 days, other behavior not directed towards others 4-6 days but less than daily. The MDS further indicated neither the resident nor family/significant other could complete the daily and activity preference portion of the assessment. The staff assessment of daily and activity preferences indicated the resident preferred receiving a tub bath, snacks between meals, staying up past 8:00 p.m., family or significant other involvement in care discussions, listening to music and spending time outdoors. R6's annual Recreation/Wellness Assessment	F 248	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Resident s #6 and resident #23 s recreation/wellness assessment have been reviewed and their care plans for activities have been updated which includes more specific activities that are appropriate for them. 2. All residents will be reviewed by the Activity department to ensure that appropriate activities are in place for each of them. 3. Education on resident appropriate activities will be completed by 2-5-16 at an all staff meeting. The activity department will create a daily activity log to ensure that appropriate activities are in place for each resident. Where difficulties may exist regarding appropriate activities for specific residents who are more challenging, the IDT will be enlisted to help develop a plan for appropriate	

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 248	Continued From page 14 dated 10/4/15, indicated information was given by R6's son from the previous assessment. The assessment identified current interests as: group participation in intergeneration programs with specific interest with school kids singing, golf cart rides, visiting in person/on phone with family, walks/bicycling. The assessment also included past preferences of watching wrestling on TV and Charlie Chan movies. R6's care plan for activities dated 10/12/15, indicated the resident was primarily independent but occasionally needed some guidance with structuring leisure activities that promote wellness. Interventions identified on the care plan: (1.) CD player in room, please play music per resident's desire. (2.) Recreation/Wellness preferences include: exercise, listening to music, watching TV (enjoys wrestling and war movies) food related activities, sensory and 1:1 time. (3.) EMOTIONAL: Offer ipod or CD player for individual music enjoyment. (4.) PHYSICAL: Encourage participation in Well-Fit program to include group exercise and/or individual cardio. The activity goal indicated R6 would work on puzzles in day room by the review period. When interviewed on 12/29/15, at approximately 8:50 a.m. the director of nursing (DON) confirmed R6 did not speak or understand English. DON further indicated staff communicated with the resident through gestures and facial expressions. Continuous observations of R6 on 12/29/15, from 1:16 p.m. until 4:17 p.m., revealed the following:	F 248	activities. 4. The Activity Director or designee will complete 2 audits weekly for 4 weeks and weekly for 2 months to ensure that the resident s are receiving activities according to their plan of care. 5. The data collected will be reviewed/discussed at the quarterly QA&A meeting. At this time the QA&A committee will make the decision/recommendation regarding any follow-up studies. The Activity Director and MDS Coordinator will be responsible for this POC. Completion date 2-8-1[illegible]	

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 248	Continued From page 15	F 248		

- At 1:16 p.m. R6 was ambulated with the assistance of two staff, a 3rd staff pushed the residents wheelchair (w/c) behind him down the west Cityside hallway. Staff were responding in English to his vocalizations. After R6 ambulated the length of the hall staff seated him back in the w/c, removed the transfer belt and transferred him to the dayroom area located by the nurses' station. Staff moved him in front to the television and then R6 propelled himself in the w/c throughout the dayroom.

- At 1:27 a.m. nursing assistant (NA)-A brought R6 a round shaped sensory item which consisted of multiple-colored hollow tubes held together with a bungy type cord. This enabled the object to be stretched and manipulated. R6 accepted the item, talking out loud constantly. Although R6 held the item, he did not appear interested nor did he attempt to manipulate or pull the sensory item. NA-A left the area after the item was delivered to R6. R6 remained in the commons area until 1:44 p.m., when licensed practical nurse (LPN)-C assisted him back to his room.

REVISED

-At 1:52 p.m. R6 left his room via the w/c to obtain water in his plastic mug from the drinking fountain located in the west hallway. Staff assisted him with the task, replaced the lid and left the area. With a water-filled mug, R6 continued to vocalize as he propelled the w/c down the west hallway. It was noted that once R6 arrived at the end of the hallway, staff intercepted and returned him back to his room.

-At 2:00 p.m., R6 was observed lying in bed on top of covers with shoes on. The sensory item given to him earlier was placed on his legs. R6 was not touching nor handling the item even

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 248	Continued From page 16	F 248		

though he appeared to be wide awake. At this time, a popcorn and movie activity was occurring in the activity room, however R6 was not assisted to attend. At 2:14 p.m. staff entered the room to distribute fresh water, greeted R6 and left immediately.

-At 2:30 p.m., R6 was seated on the edge of his bed in room with the left shoe off and was holding a shoe on his lap, removing the laces. The sensory object was no longer visualized. No music was playing in the room. From 2:39 until 4:17 p.m., R6 was observed attempting to remove and replace the lace from his left shoe. Although coffee social, wellness group and word games activities were held in the dining room at this time, R6 was not assisted or offered to attend. At 3:10 p.m. NA-C entered the room and greeted R6. Trained medication aide (TMA)-A also entered the room and asked whether R6 was still "working on his shoe". NA-C asked TMA-A whether R6 was supposed to have the shoe. TMA-A responded that if NA-C could get it laced and on R6, they could transfer him into his chair and not worry about it, however NA-C did not assist R6.

REVISED

Observations of R6 on 12/30/15 revealed the following:
- At 7:50 a.m. R6 was observed seated alone at a table in the corner of the dining room eating breakfast independently. The table was pushed flush to the wall on 2 sides. R6 had his back to the other resident's in the dining room, facing only the wall. At 7:58 a.m. R6 was assisted in the w/c by staff to the Cityside dayroom and placed at a table. Staff handed R6 a multicolored cylinder shaped sensory object that also made sound when manipulated. Staff then left the area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 248	Continued From page 17 without further interaction. R6 placed the object behind him on the seat of his w/c and proceeded to propel self past the nurses' station towards the dining room to the medication cart where LPN-C was standing. R6 vocalized loudly. LPN-C responded to R6 that he had already eaten and assisted in propelling him back to his room. LPN-C left the resident's room at 8:05 a.m. R6 was lying on his bed with the bare mattress exposed and bedding in a clump at the end of bed; no pillowcase was on R6's pillow. R6 was observed holding onto the grab bar, attempting to sit up in bed. -At 10:04 a.m. a church activity was conducted in the activity room. R6 independently propelled himself down the west hallway but once R6 turned the corned, the administrator redirected and propelled him back down the direction of the hallway. R6 then entered the dayroom, propelling self around the perimeter of the area, pausing to look out the window and then watched the activity in the fish tank. R6 propelled himself toward the direction of the east hallway and remained seated near this area until 10:30 a.m. LPN-C then moved R6 from the east hallway to a table located in the dayroom. No verbal communication nor interaction was noted between staff and R6. R6 was not offered/assisted to the church activity at anytime throughout the noted observations nor did staff interact with the resident. -At 11:07 a.m. R6 was observed seated in w/c in dayroom by nurses station; Wellness activity was currently in process and was identified on the plan of care as an planned intervention. At 11:27 a.m. R6 was seated in w/c in Cityside dayroom near nurses station when the activity director (AD) entered the dayroom, said "Hi" to R6, turned up	F 248		

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	**12/31/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 248	Continued From page 18 the volume on the TV and walked away. -At 2:35 p.m. R6 was observed in the dining room where the men's group activity was held in the main area of the dining room. No activity staff were noted to interact with R6 until they assisted out of the dining room towards the direction of his room at 2:44 p.m. When interviewed on 12/30/15, at 12:41 p.m. the AD stated R6 is very "antsy" r/t group activities and is scheduled for in-room programming. AD further indicated that 2 in-room activity programs were scheduled for 20 minutes/day. AD also stated staff will also offer coffee social time as well as the men's group activity as well as three 1:1 visits weekly. AD confirmed there was a language barrier related to attending activities and that an interpreter from the high school came to the facility on 12/4/15 but had not returned since. AD stated trying to get hold of the interpreter but calls had not been returned. AD stated a few weeks ago a representative from another facility came to assess the resident for possible placement. The representative was able to converse with R6 in his native language and discovered he enjoyed weaving baskets. When requested documentation related to activities provided for R6, the following was noted: (11/2/15 thru 12/12/15) -R6 received only two 1:1's with staff (11/4 & 11/7). The week of 11/16-11/22/15 R6 received 1:1 activity. Although the AD indicated she had provided 1:1 in-room programming with R6, she was unable to provide documentation to demonstrate this had been implemented nor could she recall when this had occurred. AD stated she offered an Ipod with headphones for R6 to listen to music in his own	F 248		

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 248		F 248		

F 248 Continued From page 19

language. The AD then provided documentation indicating the Ipod was offered 5 times in November and 4 times in December 2015. When questioned about the preferred activities (wrestling and war movies) documented on R6's care plan, she indicated being unaware of these preferences. When the current activity sheets were reviewed to substantiate the activities each resident had attended, there was nothing highlighted and/or documented indicating that R6 had been involved in activities during the days of observations.

When further interviewed on 12/31/15, at 10:21 a.m. the AD was unable to provide documentation of activities offered in 11/15 and provided 5 days of activity sheets for 10/15 and provided only ten days of documentation for 12/15. The sheets indicated R6 attended exercise on 12/21/15, and the AD stated he did really well with it. The activity sheets failed to document whether R6 had participated, wandered away and/or refused the activity; the AD confirmed the activity documentation was incomplete.

REVISED

R23
R23 was admitted on 1/6/15 with diagnoses including: dementia, paranoid personality, mood disorder, and chronic obstructive pulmonary disease (COPD) per the facility diagnosis report. The report further identified R23 was admitted to hospice services on 5/15/15 due to senile degeneration of the brain.

R23's quarterly Minimum Data Set (MDS) assessment dated 11/6/15, indicated R23 severely impaired cognition, total dependence with locomotion on/off unit, and extensive assistance with bed mobility, transfer, eating,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	**12/31/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 248	Continued From page 20	F 248		

toilet use, and personal hygiene.

R23's significant change MDS assessment dated 5/6/15, indicated activity preferences as: very important to have books, magazines, newspapers to read, very important to do favorite activities, very important to go outside and get fresh air when weather is good, and very important to participate in religious services or practices.

R23's care plan last revised 11/9/15, indicated the resident was dependent on staff for structuring and providing activities that promote wellness stimulation due to cognitive deficits. Interventions included: (1) "1 to 1 bedside/in-room visits and activities if [resident name] is unable to attend out of room events. (2) COGNITIVE: Encourage participation in small groups and/or 1:1 interactions (3) EMOTIONAL: Offer ipod or CD player for individual music enjoyment. (4) ENVIRONMENTAL: Observe [resident name] body language related to over stimulation [Resident name] Recreation/Wellness individual preferences include Bingo, walks, magazines, word search, TV and listening and playing music."

R23 was observed continuously on 12/29/15, from 1:14 p.m. until 3:56 p.m. while lying in bed. A popcorn and move activity was held at 1:30 p.m. in the activity room and the coffee social activity held at 2:30 p.m. in the dining room. Staff did not offer R23 the opportunity to attend either activity.

R23 was again observed continuously on 12/30/15, from 10:03 a.m. until 10:23 a.m. At 10:03 a.m. R23 was seated in a geri chair in the Cityside dayroom at a table while a church service was currently being held in the activity

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 248	Continued From page 21	F 248		

room.

At 10:21 a.m. R23 remained in the geri-chair with eyes closed. The AD approached another resident seated in w/c located near the Cityside nurses station and asked whether she wanted to attend church. R23 opened her eyes when the AD and the resident left for church but looked away and closed her eyes when they left the area. NA-A then approached R23 at 10:23 a.m. to ask whether she wanted to lay down. R23 nodded "yes". NA-A did not give her the opportunity to attend the church activity before transporting her to her room.

At 11:08 a.m. R23 was observed lying in bed with eyes closed while a Wellness activity was in process. She had not been given the opportunity to attend this activity.

REVISED

At 3:12 p.m. R23 was again lying in bed with eyes closed. A music activity was being performed in the Cityside dayroom with a resident's family member piano playing. Staff were not observed to offer attendance to the activity to R23.

When interviewed on 12/30/15, at 11:55 a.m. NA-B and NA-A confirmed they had assisted R23 with her morning cares, stating that when offered activities, she often refuses as prefers to lie down. Both NA's confirmed they had not offered R23 attendance at the morning church activity as R23 had been tearful that morning when receiving care and they felt the resident would rather lie down. NA-B further stated the resident liked to color when first admitted and will attend church though at times will become disruptive during the service.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	**12/31/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 248	Continued From page 22	F 248		

When interviewed on 12/30/15, at 1:40 p.m. the AD stated R23's activities included hair care, a daily Sunshine group (sensory group) which is implemented twice daily Monday-Friday and once on Saturdays). AD stated the resident usually does fine while attending church service but sometimes needed to be removed from the service as would get agitated. AD confirmed she would still expect R23 be offered the opportunity to participate in attending church. AD attempted to located documentation of activities attended and 1:1's provided for R23. The 1:1 activity sheets indicated R23 was to have 1:1's three times/weekly. AD provided 1:1 documentation from 11/2/15 - 12/5/15 (minus the week of 11/16/15 - 11/22/15); R23 was provided a 1:1 on 7 occasions during this period (11/5/15, 11/7/15, 11/12/15, 11/13/15, 11/27/15, 12/4/15, 12/7/15.) AD confirmed the 1:1 charting was inadequate and did not identify the activity, time and/or response. Staff would not be able to evaluate effectiveness of planned interventions.

When interviewed on 12/31/15, at 10:21 a.m. the AD provided 10 days of December 2015 activity sheets for R23. The sheets indicated R23 was offered activities on 5 of the 10 days. AD was unable to provide documentation of activities offered in November 2015 and provided 5 days of activity sheets for October 2015. The activity sheets did not include evidence if the resident had participated or refused the activity; AD confirmed the charting of activities was incomplete.

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 248	Continued From page 23	F 248		
F 282 SS=D	. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care related to activities for 2 of 3 (R6, R23) residents reviewed for activities. Findings include: R6 When interviewed on 12/29/15, at approximately 8:50 a.m. the director of nursing (DON) confirmed R6 did not speak or understand English. DON further indicated staff communicated with the resident through gestures and facial expressions.	F 282	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Resident #6 and Resident #23 plan of	2/8/16

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 282 — Continued From page 24

R6 was admitted to the facility on 9/5/14, with diagnoses including dementia without behavioral disturbance, cognitive communication deficit, chronic obstructive pulmonary disease (COPD), muscle weakness and difficulty walking per the facility diagnosis report.

R6's care plan for activities dated 10/12/15, indicated the resident was primarily independent but occasionally needed some guidance with structuring leisure activities that promote wellness. Interventions identified on the care plan:
1. CD player in room please play music per resident's desire.
2. Recreation/Wellness preferences include exercise, listening to music, watching TV (enjoys wrestling and war movies) food related activities, sensory and 1:1 time.
3. EMOTIONAL: Offer ipod or CD player for individual music enjoyment.
4. PHYSICAL: Encourage participation in Well-Fit program to include group exercise and/or individual cardio. The activity goal indicated R6 would work on puzzles in day room by the review period.

On 12/29/15, R6 was observed continuously from 1:16 p.m. until 4:17 p.m.

- At 1:16 p.m. R6 was ambulated with the assistance of two staff, a 3rd staff pushed the residents wheelchair (w/c) behind him down the west Cityside hallway. After R6 ambulated the length of the hall staff seated him back in the w/c, removed the transfer belt and transferred him to the dayroom area located by the nurses' station. Staff moved him in front to the television and then

F 282 (Provider's Plan of Correction)

care related to activities was reviewed and updated to meet their individualized needs.
2. All residents are assessed for their activity preferences upon admission, quarterly and with a significant change in condition and care plans are updated to ensure appropriate interventions are implemented. All Residents have had their care plans reviewed to ensure that each of them are receiving appropriate activities. A special care plan meeting hosted by the Activities Director will be conducted quarterly to ensure that activities are being instituted and conducted in accordance with proper care planning, this special meeting will be documented and will involve members of the IDT. This meeting will be in addition to care plan updates on admission, quarterly, and on change in condition.
3. Education will be completed by 2-5-16 for all staff on following interventions care planned for all residents.
4. The DNS or designee will complete two audits per week for 4 weeks and then weekly for two months to ensure compliance in these areas.
5. The data collected will be reviewed/discussed at the quarterly QA&A meeting. At this time the QA&A committee will make the decision/recommendation regarding any follow-up studies.

The DNS and Activity Director will be responsible for this POC.
Completion Date: 2-8-16

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 282	Continued From page 25 R6 propelled himself in the w/c throughout the dayroom. -At 1:27 a.m. nursing assistant (NA)-A brought R6 a round shaped sensory item which consisted of multiple-colored hollow tubes held together with a bungy type cord. This enabled the object to be stretched and manipulated. R6 accepted the item, talking out loud constantly. Although R6 held the item, he did not appear interested nor did he attempt to manipulate or pull the sensory item. NA-A left the area after the item was delivered to R6. -At 1:34 p.m. a staff member transported R6 from the middle of the day room to a table with another resident. R6 continued to verbalize while the sensory object remained on his lap. No interaction between staff and R6 occurred. R6 remained at the table a short time and then began to propel the w/c around the dayroom. -At 2:00 p.m., R6 was observed lying in bed on top of covers with shoes on. The sensory item given to him earlier was placed on his legs. R6 was not touching nor handling the item even though he appeared to be wide awake. At this time, a popcorn and movie activity was occurring in the activity room. -At 2:07 p.m. it was noted that R6 was sitting up on edge of bed with feet dangling down; the sensory item remained on resident's lap. It was again noted that R6 was not touching nor interested in this sensory object. -At 2:30 p.m., R6 was seated on the edge of his bed in room with the left shoe off and was holding a shoe on his lap, removing the laces. The	F 282		

REVISED

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 282	Continued From page 26	F 282		

sensory object was no longer visualized. No music was playing in the room.

-At 2:39 p.m., R6 remained seated at the edge of the bed attempting to pull the laces from his left shoe. R6 had a nebulizer mask on and no staff were present in the room during this observation. Coffee social and word games activities were held in the dining room at this time.

-At approximately 2:50 p.m., LPN-D in R6's room attending to the nebulizer machine while R6 continued to sit on edge of bed attempting to remove the laces from his left shoe. At 2:56 p.m. R6 remained seated at the edge of bed holding onto the unlaces left shoe. At 3:10 p.m. NA-C entered the room and greeted R6. Trained medication aide (TMA)-A also entered the room and asked whether R6 was still "working on his shoe". NA-C asked TMA-A whether R6 was supposed to have the shoe. TMA-A responded that if NA-C could get it laced and on R6, they could transfer him into his chair and not worry about it. On 12/29/15, at 3:57 p.m. R6 remained seated on the side of bed, holding his left shoe without laces. R6 appeared to be examining the shoe. The Wellness group was on the activity schedule for 4:00 p.m. At 4:17 p.m. R6 remained seated on edge of bed, holding onto the left shoe and was attempting to replace the laces back in the shoe. This activity had been continuous since 2:30 p.m. (almost 2 hours).

R6 was not offered/assisted to scheduled activities during the 3 hours of continuous observation on 12/29/15. The plan of care was not followed as written. R6 was handed a sensory object though staff failed to model how object could be used and/or spend time any time

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 282	Continued From page 27 with R6. It was observed on 12/30/15, at 10:04 a.m. a church activity was conducted in the activity room. R6 independently propelled himself down the west hallway but once R6 turned the corned, the administrator redirected and propelled him back down the direction of the hallway. R6 then entered the dayroom, propelling self around the perimeter of the area, pausing to look out the window and then watched the activity in the fish tank. R6 propelled self toward the direction of the east hallway and remained seated near this area until 10:30 a.m. LPN-C then moved R6 from the east hallway to a table located in the dayroom. No verbal communication nor interaction was noted between staff and R6. R6 was not offered/assisted to the church activity at anytime throughout the noted observations nor did staff interact with the resident. On 12/30/15, at 11:07 a.m. R6 was observed seated in w/c in dayroom by nurses station; Wellness activity was currently in process and was identified on the plan of care as an planned intervention. At 11:27 a.m. R6 was seated in w/c in Cityside dayroom near nurses station when the activity director (AD) entered the dayroom, said "Hi" to R6, turned up the volume on the TV and walked away. At 2:35 p.m. R6 was observed in the dining room where the men's group activity was held in the main area of the dining room. R6 was served a snack while located in the front area of the main dining room, partitioned off by a wall with 2 openings. R6 was offered his snack at the table where he routinely consumed his meals. R6 was left alone in the front area of the dining	F 282		

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 282	Continued From page 28	F 282		

room while the other residents were served their snack in the main area. At 2:41 p.m. when R6 finished his snack, propelled himself around the front area of the dining room near his designated table. No activity staff were noted to interact with R6 until they assisted out of the dining room towards the direction of his room at 2:44 p.m.

When interviewed on 12/30/15, at 12:41 p.m. the AD stated R6 is very "antsy" r/t group activities and is scheduled for in-room programming. AD further indicated that 2 in-room activity programs were scheduled for 20 minutes/day. AD also stated staff will also offer coffee social time as well as the men's group activity as well as three 1:1 visits weekly.
When questioned about the preferred activities (wrestling and war movies) documented on R6's care plan, she indicated being unaware of these preferences. When the current activity sheets were reviewed to substantiate the activities each resident had attended, there was nothing highlighted and/or documented indicating that R6 had been involved in activities during the days of observations.

When further interviewed on 12/31/15, at 10:21 a.m. the AD provided 10 days of December 2015 activity sheets which indicated R6 was offered activities on 8 of the 10 days. AD stated the activity sheet dated 12/21/15, indicated the resident was offered the exercise activity. AD stated she sat next to R6 during the activity and he did really well. However, the AD was unable to provide documentation of activities offered in November 2015 and provided 5 days of activity sheets for October 2015. It was confirmed the plan of care was not implemented as written.

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 282	Continued From page 29	F 282		

R23
R23 was admitted on 1/6/15 with diagnoses including: dementia, paranoid personality, mood disorder, and chronic obstructive pulmonary disease (COPD) per the facility diagnosis report. The report further identified R23 was admitted to hospice services on 5/15/15 due to senile degeneration of the brain.

R23's care plan last revised 11/9/15, indicated the resident was dependent on staff for structuring and providing activities that promote wellness stimulation due to cognitive deficits. Interventions included: (1) "1 to 1 bedside/in-room visits and activities if [resident name] is unable to attend out of room events. (2) COGNITIVE: Encourage participation in small groups and or 1:1 interactions (3) EMOTIONAL: Offer ipod or CD player for individual music enjoyment. (4) ENVIRONMENTAL: Observe [resident name] body language related to over stimulation [Resident name] Recreation/Wellness individual preferences include Bingo, walks, magazines, word search, TV and listening and playing music."

R23 was observed continuously on 12/29/15, from 1:14 p.m. until 3:56 p.m. while lying in bed. A popcorn and move activity was held at 1:30 p.m. in the activity room and the coffee social activity held at 2:30 p.m. in the dining room. Staff did not offer R23 the opportunity to attend either activity.

R23 was again observed continuously on 12/30/15, from 10:03 a.m. until 10:23 a.m. At 10:03 a.m. R23 was seated in a geri chair in the Cityside dayroom at a table while a church service was currently being held in the activity room.

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 282	Continued From page 30	F 282		

At 10:21 a.m. R23 remained in the geri-chair with eyes closed. The AD approached another resident seated in w/c located near the Cityside nurses station and asked whether she wanted to attend church. R23 opened her eyes when the AD and the resident left for church but looked away and closed her eyes when they left the area. NA-A then approached R23 at 10:23 a.m. to ask whether she wanted to lay down; R23 nodded "yes". NA-A did not give her the opportunity to attend the church activity before transporting her to her room.

At 11:08 a.m. R23 was observed lying in bed with eyes closed while a Wellness activity was in process. She had not been given the opportunity to attend this activity.

REVISED

At 3:12 p.m. R23 was again lying in bed with eyes closed. A music activity was being performed in the Cityside dayroom with a resident's family member piano playing. Staff were not observed to offer attendance to the activity to R23.

When interviewed on 12/30/15, at 11:55 a.m. NA-B and NA-A confirmed they had assisted R23 with her morning cares, stating that when offered activities, she often refuses as prefers to lie down. Both NA's confirmed they had not offered R23 attendance at the morning church activity as R23 had been tearful that morning when receiving care and they felt the resident would rather lie down.

When interviewed on 12/30/15, at 1:40 p.m. the AD stated R23's activities included hair care, a daily Sunshine group (sensory group) which is implemented twice daily Monday-Friday and once

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	**12/31/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 282	Continued From page 31 on Saturdays). AD confirmed she would still expect R23 be offered the opportunity to participate in attending church. AD attempted to located documentation of activities attended and 1:1's provided for R23. The 1:1 activity sheets indicated R23 was to have 1:1's three times/weekly. AD provided 1:1 documentation from 11/2/15 - 12/5/15 (minus the week of 11/16/15 - 11/22/15); R23 was provided a 1:1 on 7 occasions during this period (11/5/15, 11/7/15, 11/12/15, 11/13/15, 11/27/15, 12/4/15, 12/7/15). When interviewed on 12/31/15, at 10:21 a.m. the AD provided 10 days of December 2015 activity sheets for 23. The sheets indicated R23 was offered activities on 5 of the 10 days. AD was unable to provide documentation of activities offered in November 2015 and provided 5 days of activity sheets for October 2015. The activity sheets did not include evidence if the resident had participated or refused the activity; AD confirmed the charting of activities was incomplete. The plan of care was not implemented as written.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309		2/8/16

REVISED

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ____ B. WING ____	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309 Continued From page 32

Based on interview and document review, the facility failed to provide adequate nursing care and services for 2 of 4 residents (R46, R21) reviewed who had been hospitalized. This resulted in actual harm for R46, who experienced prolonged discomfort, dehydration and vomiting related to delayed nursing assessment and transfer to an inpatient facility for a small bowel obstruction. In addition, the facility failed to provide appropriate interventions related to dementia care for 1 of 1 resident (R6) reviewed who had dementia and could not speak/understand English.

Findings include:

R46's discharge orders to the nursing home dated 9/17/15, identified a discharge condition of improving with orders for physical and occupational therapy.

R46's physician's progress notes, dated 9/18/15 indicated diagnoses of spinal stenosis of the lumbar region, sepsis, and urinary tract infection. The physician's progress note also identified a history of diverticulitis of the colon.

R46's admission Minimum Data Set (MDS), dated 9/24/15 identified a Brief Interview for Mental Status score of 13/15 (cognitively intact). No care area assessments were completed with the MDS.

R46's care plan, dated 9/30/15 identified no cognitive impairments and that R46 desired to return to the community.

R46's September 2015 medication sheets revealed R46 had received Maalox (an antacid) 30 cubic centimeters (cc)'s on 9/25/15 a total of

F 309

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:

1. Resident #46 is deceased. The facility found a more appropriate placement for resident #6. This facility has Hmong speaking staff. This resident will be closer to his family and be placed in a dementia unit that is a quieter setting as recommended by his primary physician.
2. All residents have been reviewed to ensure that any non-English speaker has someone in the facility who speaks their language. All residents have been reviewed for any significant change in condition and need to notify the physician and DNS.
3. Education to licensed staff will be completed by 2-3-16 on significant change in resident condition, physician notification per phone call and DNS notification with any change in resident condition and the importance of having someone available to speak the language of all non-English speaking residents.
4. Nurses will notify the physician immediately (in a timely manner) when residents have a significant change in condition and they will also notify the

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 309	Continued From page 33	F 309		

four times on that date, as well as one dose at 2:00 a.m. on 9/26/15. Notations documented by licensed practical nurse (LPN)-A, on the back of the medication administration record for a dose administered on 9/25/15, at 2:00 a.m. indicated the medication had been given for stomach upset since supper. No follow up assessment for effectiveness was completed. A subsequent entry dated 9/26/15, at 2:00 am. indicated R46 had received another dose of Maalox for an upset stomach and emesis; the follow up result was listed as had another emesis at 4 a.m. None of the other doses administered had follow up results documented.

A nursing progress note written by LPN-F on 9/25/15 at 8:30 a.m., indicated R46 had hiccups and complaints of not feeling well. The notes indicated R46 had been given Maalox 30 cc's along with Thorazine and had begun retching after his morning medications. In addition, R46 had experienced a large projectile emesis all over the bed and himself, and had refused to eat anything for breakfast, stating he had consumed orange juice that had all come up.

A nursing progress note documented by LPN-F on 9/25/15, at 1:39 p.m. indicated R46 had a large emesis, and that the resident had stated he was not feeling well. The notes indicated his hiccups had subsided for a while but had then started again. Documentation indicated R46 had received Maalox and Thorazine (an antipsychotic medication used for antiemetic properties) with another small emesis afterward. The emesis was documented as having had food particles present and was described as having a colicky odor. R46's temperature was documented as having been elevated at 99.0 degrees Fahrenheit (F).

Director of Nursing. They will no longer use fax to communicate these serious issues regarding residents. Prior to admission the facility will ensure that there is someone available who speaks the language of any non-English speaker.
5. The DNS or designee will complete 2 audits weekly for 4 weeks and weekly for 2 months to ensure that the facilities guideline is being followed correctly.
6. The data collected will be reviewed/discussed at the quarterly QA&A meeting. At this time the QA&A committee will make the decision/recommendation regarding any follow-up studies.

The DNS is responsible for this POC.
Completion Date: 2-8-16

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 34 A nursing progress note dated 9/25/15, at 6:00 p.m. per LPN-F indicated R46 had stayed in bed most of the evening. The note indicated R46's hiccups were better over the early evening hours but that R46 had been stated his tummy still didn't feel right and that whenever he moved he began to gag. R46 had eaten Jell-O for supper and had sips of water. Additionally, the documentation indicated a fax (facsimile) had been sent to medical doctor (MD)-A with an update on R46's condition including that R46 had an elevated temperature at 99.5 degrees F and complained of feeling chilly. A nursing progress note dated 9/25/15, at 1[illegible]:05 p.m. per LPN-F indicated R46 had not been feeling well, and had been having brown colored emesis twice on the afternoon shift which did not appear to have a feces odor. Maalox 30 cc's had been given to help with hiccups and R46's vitamins had been held due to emesis. A nursing progress note by LPN-A, dated 9/26/15, at 1:56 a.m. indicated R46's abdomen was distended, his bowel sounds were difficult to hear and he had been having emesis which looked like BM. R46's temp was noted to be slightly elevated at 99.1 degrees F. A nursing progress note written by LPN-A on 9/26/15, at 4:48 a.m. indicated R46 had 100 cc's of emesis, like soft formed/loose BM (bowel movement) with no odor. The note further indicated R46 was cool and clammy, with a slightly elevated temperature at 99.1 degrees F. R46 had a wastebasket beside him, and continued to wretch.	F 309		

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 309	Continued From page 35	F 309		

A nursing progress note entered by LPN-B, dated 9/26/15, at 9:57 a.m. indicated R46 had two further emesis of greenish liquid thick with pieces of BM looking in it. In addition, the note indicated an acute care hospital had been called and an order was received to transfer R46 to their emergency room (ER) via ambulance. The note indicated R46's daughter was updated and had agreed to meet him at the hospital. R46 left the facility at 8:45 a.m.

A faxed physician's order dated 9/26/15 was present in R46's record and verified the physician order to transfer per ambulance to the acute care hospital.

REVISED

An additional nursing progress note dated 9/26/15, at 2:06 p.m. indicated R46 had been admitted to the acute care hospital with a diagnoses of bowel obstruction, and would need surgery.

A faxed physician's order sent on 9/25/15, at 6:05 p.m. from the facility to R46's primary physician identified that R46 had emesis since 8:30 a.m., experienced several rounds of hiccups throughout the day and had been unable to eat or drink. R46 complained of feeling weak. The fax had not been signed off until on 9/28/15, three days later, when the nurse practitioner (NP)-A responded with a statement including, "Noting telephone order to transfer to ER on 9/26/15. Please do NOT fax in regard to situations that need attn [attention] that day. This will be sent to [physician] - today 9/28/15. Please review the faxing for response procedure. Thx [Thanks]."

The ER progress note dated 9/26/15, at 10:36 a.m. was reviewed. The ER note indicated R46

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 309	Continued From page 36	F 309		

had appeared distressed when examined, had been uncomfortable, and had dry oral mucous with dried brown material on the tongue and lips. The ER note further indicated R46's abdomen was firm and diffusely distended, mildly tender with no appreciable bowel sounds. In addition, 1800 milliliters (ml) of brown liquid had been drained from R46's stomach after the insertion of a nasogastric tube. R46 had received 2000 ml of normal saline intravenous for hydration. The ER physician's note indicated R46 had appeared quite dehydrated and verified the admitting diagnoses of small bowel obstruction and severe dehydration.

The ER registered nurse's assessment dated 9/26/15, at 11:17 a.m. indicated: R46 had stated he'd been vomiting for the last two days and his emesis was now brown like stool. R46 had vomited three times in the ambulance enroute to the ER and the vomit was described as dark brown liquid running out of his mouth. R46's abdomen was very firm, with no bowel sounds and the abdomen was distended. R46 complained of abdominal pain but was unable to rate the pain. R46 had his stomach drained via a nasogastric tube for ten minutes with 1400 mL of fluid output after which R46 stated he felt much better. R46 was alert and "states we should do what ever we have to do. Is comfortable now."

The hospital discharge summary dated 10/5/15, indicated R46 had undergone abdominal surgery to correct the small bowel obstruction, and had developed subsequent cardiac and anticoagulation issues as well as post-operative ileus (disruption in normal bowel motility) after the surgery. The ileus resolved with the replacement of a nasogastric tube; however, comfort cares

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 37	F 309		

were initiated and R46 passed away on 10/5/15.

During interview on 12/29/15, at 3:07 p.m. the director of nursing (DON) verified she would have expected staff to contact the on-call doctor immediately with the urgent clinical issues, especially when the resident was vomiting BM-type material and not feeling better.

During interview on 12/29/15, at 3:32 p.m. the nursing home's health information coordinator/nursing scheduler (HIM) stated LPN-B was not well and was currently in a hospital intensive care unit, unavailable for interview. The HIM verified LPN-[illegible] had been a pool nursing staff.

During interview on 12/29/15, at 3:45 p.m. the acting administrator, who had been the DON at the time of the incident stated she'd thought R46's family had indicated he was admitted to the hospital with a bowel obstruction, but that it had later been found to be a narrowed bowel. The administrator was unable to recall specifics regarding R46's episode of illness; however, stated she would have expected staff to contact/call the on-call and/or primary physician directly with concerns that were urgent. The administrator stated she would have expected the staff to check the vital signs, bowel movement status, appetite and fever status while conducting a physical assessment. The administrator stated she thought LPN-A was a good nurse and trusted her judgment. She further verified LPN-A worked every Thursday night shift.

When LPN-A was interviewed about the incident on 12/29/15 at 4:02 p.m., LPN-A stated she'd received report from the evening nurse (LPN-F)

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 38 on 9/25/15, regarding R46's emesis, but had been unaware a fax had been sent. LPN-A stated she'd worked with R46 at least one time prior and was aware R46's vomiting and complaints of not feeling well was new for R46. She was aware R46 had thrown up and had not been eating well, and had subsequently administered Maalox during the night. LPN-A thought the Maalox had helped somewhat the first time she administered it (around 2:00 a.m.). LPN-A verified R46 had emesis of what looked like stool but there was no odor. She verified his abdomen had also seemed a little distended. LPN-A was unaware whether R46 had complained of pain. LPN-A said R46 subsequently vomited and it looked more like BM later in her shift (around 5:00 a.m.) at which time she'd become concerned that he may have something wrong with his small bowel. LPN-A said she'd proceeded to fill out all the transfer paperwork for a hospital discharge; however, did not call the RN on call nor notify the physician of her concern. LPN-A indicated she had passed along the paperwork and her concern to the day nurse, LPN-B, who arrived on duty at 6:00 a.m. on 9/26/25. LPN-A stated she'd told LPN-B to do an assessment to follow up on R46's condition. During the interview, LPN-A stated she thought there had been a history of small bowel concerns she had noted when filling out the paperwork to pass along to the day shift personnel. During a follow up interview on 12/30/15, at 9:12 a.m. the administrator stated LPN-A should have notified the physician sooner about R46's symptoms, and that she had not been aware there had been a delay in his nursing care and physician notification of his condition.	F 309		

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 39 During interview on 12/30/15, at 2:11 p.m. the medical director was interviewed and stated she would have expected nursing staff to call when they filled out the paperwork to transfer R46 to the hospital. The medical director stated although R46 may have subsequently expired anyway, prompt medical care would have made him comfortable. The medical director stated the effect of delayed medical care/interventions related to R46's medical outcome was difficult to state since she was not his usual physician. During interview on 12/31/15, at 9:27 a.m. medical doctor (MD)-A (R46's usual physician) stated he would have expected staff to have called the clinic and/or the on-call physician when R46 began vomiting stool-like material. MD-A stated faxing medical staff at the clinic at 6:00 p.m. was inappropriate as the fax machine was not attended at that time of day. MD-A stated he'd been concerned about the potential for ischemic bowel when R46 arrived at the hospital, due to the delay in receipt of medical attention after his symptoms began. MD-A stated R46 had made some "depressed" comments prior to the hospital transfer on 9/26/15, but those comments were a "sidebar" and were not relevant to this issue. MD-A confirmed R46 would have been more comfortable if he had been examined sooner in the ER. MD-A stated, "when you are vomiting brown stuff, it is probably a good idea if you are seen." The facility's policy entitled Change in Condition SBAR last revised 3/15, indicated immediate notification of the physician was required for any symptom, sign or apparent discomfort that was sudden in onset, a marked change (i.e. more severe) in relation to usual signs and symptoms	F 309		

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 309	Continued From page 40	F 309		

and was unrelieved by measures already prescribed. The policy further indicated in a section related to abdominal distension that immediate notification of the physician was required when there was rapid onset, or presence of marked tenderness, fever, vomiting or GI (gastrointestinal) bleeding.
Review of R21's Medication Administration Record (MAR) dated December 2015, identified that blood sugar (BS) readings were monitored five (5) times per day. Between the dates of 12/1 - 12/29/15 there were 44 blood sugar (BS) levels which were documented as 400 milligrams (mg)/ deciliter (dL) and above, with 25 of those documented BS level readings higher than 430 mg/dL. Although the resident's blood sugars fluctuated dramatically, there had not been physician notification of blood sugars which registered greater than 430 mg/dL.

A physician's order, dated 11/3/15 indicated, Insulin Regular Human Solution 100 unit/milliliter (ml) Inject as per sliding scale with the final ordered dosage "greater than 400 mg/dL: give 6 units".

A physician's order, dated 12/7/15 indicated, Insulin Glargine Solution 100 unit/ml- 24 units subcutaneous (SQ) one time per day (QD), and sliding scale with Regular Humalog solution 100 unit/ml. BS readings were to be faxed to the diabetic educator weekly. No parameters were listed for notification of the physician regarding hypo (low) or hyper (high) glycemia (BS).

During interview on 12/30/15, at 3:10 p.m. a licensed practical nurse (LPN)-C indicated there were no protocols, or orders, indicating when to notify the medical doctor (MD) of BS levels.

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 309	Continued From page 41	F 309		

LPN-C stated she would notify the MD related to how the resident felt and if there was a high BS-which she identified as "way above 400's-500's".

On 12/30/15, at 2:36 p.m. LPN-D stated she would notify the MD if she obtained a BS result above 600 mg/dL. LPN-D confirmed on 12/29/15, the supper BS check for R21 was 521 mg/dL and the MD was not updated. LPN-D further stated R21 frequently has BS readings above 400 mg/dL and the facility standing orders read to give 6 units of regular insulin if the BS was greater than 350 mg/dL. LPN-D indicated when the glucometer read "high" it was the result of a BS over 600 mg/dL and she would telephone the nurse on call at the hospital to report the reading.

During interview on 12/30/15, at 2:57 p.m. the diabetic educator indicated she received weekly reports of R21's BS results. She further stated the clinic has a protocol for diabetic medication adjustments and this was what insulin changes were based upon. The diabetic educator further stated R21 had a history of being a brittle diabetic and nursing staff were supposed to call the medical provider on call and/or the triage nurse related to changes in status. The diabetic educator further indicated she thought BS parameters had been identified when R21 was recently discharged from the the hospital on 12/5/15. She indicated the parameters would have been determined by the discharging MD.

During interview on 12/30/15, at 3:12 p.m. RN-B and RN-C stated there were facility parameters for reporting BS readings. They referenced the documentation on the facility's standing orders

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 42	F 309		

and stated that would be the practice they followed unless individualized orders were written. RN-B indicated if a resident was symptomatic she would notify the physician based on the standing order instructions. RN -B and RN-C indicated they were not aware of the Change in Condition policy related to immediate reporting of BS readings above 430 mg/DL. RN-B stated, "we will have to make certain everyone is aware of this policy".

During interview on 12/31/15, at 8:36 a.m. LPN-E indicated she had been employed as an LPN for 3 months at the facility and had received training on BS checks which included: to test in a private area, wear gloves, and follow MD orders if the resident had orders for a sliding scale (SS), or a specific insulin order. LPN-E stated if there was a "high" reading she would contact the MD on call for direction. In the instance of a 400+ reading for R21 LPN-E indicated she would administer the ordered SS dose and recheck in one hour and then recheck in the following hour to determine whether the BS was responding to insulin. LPN-E stated she would probably not notify the MD in this instance as this resident has a history of BS fluctuations. LPN-E further indicated R21 did not have specific orders for follow up but this is what she would do.

On 12/31/15, at 9:04 a.m. R21's physician, also the facility's medical director, stated typically a resident would have a specific order that comes from the hospital for sliding scale insulin. R21's physician stated R21 had been her patient even before admission to the nursing home, and had a history of blood sugars fluctuating "all over" but that the resident was usually most comfortable when her blood sugars ran over 300 mg/dl.

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 309	Continued From page 43	F 309		

However, stated if she'd received a telephone call for an elevated blood sugar level she could provide specific orders as to when staff were required to recheck the BS and call back the results. She stated, "they call if the meter reads 'hi' because they have nothing to base it off. If the blood sugar is below 70 mg/dL staff would need to initiate the hypoglycemia protocol." She further indicated she would expect staff to notify the clinic and/or on-call staff to update on BS readings that were outside range.

When interviewed on 12/31/15, at 1:00 p.m. the director of nursing (DON) reviewed the December 2015 documentation of R21's BS readings and indicated she was unaware of the wide fluctuation of BS readings for R21 which were over 430 mg/dL. She confirmed she would have expected staff to notify the attending MD and/or the on-call staff in accordance with the Change in Condition When to Report to the MD/NP/PA policy.

REVISED

The facility's policy related to physician notification for blood sugar fluctuations, entitled, Change in Condition When to Report to the MD/nurse practitioner(NP)/physician assistant last revised 3/15, included: "blood sugars greater than 430 mg/dL (or machine registers high) in diabetic patients using sliding scale insulin should be immediately reported to the physician or nurse practitioner (NP)."
When interviewed on 12/29/15, at approximately 8:50 a.m. the DON confirmed R6 was unable to understand or be understood, and staff communicated using gestures and facial expressions.

The facility diagnostic report indicated R6 was admitted to the facility in 2014, with diagnoses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 309	Continued From page 44	F 309		

including dementia without behavioral disturbance with a cognitive communication deficit.

R6's annual MDS assessment dated 10/9/15, revealed the resident had severely impaired cognition with daily wandering that significantly intruded on the privacy of others, physical behavior towards others 1-3 days, other behavior not directed towards others 4-6 days but less than daily. The MDS also indicated R6 required extensive assistance with bed mobility, transfer, locomotion on/off unit, dressing, toilet use, and personal hygiene. The MDS further indicated neither the resident nor family/significant other was able to complete the daily and activity preference portion of the assessment.

R6's care plan dated 10/12/15, indicated a risk for falls related to (r/t) history of falls, generalized weakness, gait/balance problems, bladder incontinence, hearing and vision impairments, impaired cognition, and difficulty communicating needs. Interventions included: anticipate and meet needs, encourage activities that promoted exercise, physical activity for strengthening and improved mobility, ambulate with staff in hallway three times daily, redirect when wheeling close to wall or objects, use distraction when restless. The care plan further identified a communication problem r/t hearing deficit and head injury. Interventions included: discuss with resident/family concerns or feelings regarding communication difficulty, family reported that they were unable to communicate with resident due to the progression of his dementia, observe effectiveness of communications strategies and assistive devices.

On 12/29/15, R6 was continuously observed from

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	**12/31/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 309	Continued From page 45 1:16 to 4:17 p.m.: - At 1:16 p.m. R6 was observed being ambulated by two staff with a third pushing the resident's wheelchair (w/c) behind him down the west "Cityside" hallway. The resident was cooperative while walking and although could not be understood, spoke and smiled to the staff, who in turn talked to the resident. After walking the length of the hall, the resident was assisted back to the dayroom in front of the television (TV). R6 then propelled himself throughout the dayroom in his w/c. -At 1:27 p.m. NA-A brought R6 a sensory item that was rounded in shape and consisted of multiple-colored hollow tubes held together with a -type cord enabling the object to be stretched and manipulated. R6 accepted the item, talking out loud constantly and NA- walked away. R6 held the item but did not appear interested, nor did he attempted to manipulate the object. -At 1:34 p.m. a staff member transported R6 from the middle of the dayroom to a table with another resident. R6 continued to verbalize while the sensory object remained in his lap. No interaction with staff and R6 was observed. R6 remained at the table for a short time and then began to propel himself in w/c around the dayroom. -At 1:44 p.m. R6 started to propel behind the nurses' station. LPN-C redirected the resident away from the area and then assisted him to his room. -At 1:52 p.m. R6 propelled himself out of his room to the drinking fountain in the west hallway. R6 had a plastic mug and was attempting to obtain	F 309		

REVISED

F 309 Continued From page 46 F 309

water from the fountain. A staff member approached R6 and assisted him with filling the mug with water then replaced the cover on the mug. R6 accepted the water mug then continued to mumble out loud and propel himself down the west hallway towards the administrative offices. Once R6 made it to the end of the hallway, staff intercepted the resident and returned him to his room.

-At 2:00 p.m., R6 was lying in bed on top of covers without shoes. A sensory item the resident was holding earlier was on the resident's legs. R6 eyes were wide open.

-At 2:07 p.m. R6 was sitting up on the edge of the bed with feet dangling, and the sensory item was on his lap. The resident was not touching or paying attention to the sensory object.

REVISED

- At 2:30 p.m. R6 was seated on the edge of his bed. His left shoe was off his foot, as he held his other shoe and pulled out the laces.

-At 2:39 p.m., R6 continued to sit on the edge of bed in room attempting to pull the laces out of his left shoe. Coffee social and word games activity was being conducted in the dining room at that time. At 2:56 p.m. R6 continued to sit on edge of bed having successfully removed the laces from his shoe. At 3:10 p.m. NA-C entered R6's room and greet him. A trained medication aide (TMA)-A entered the room and asked if the resident was still "working on his shoe." NA-C asked if R6 was supposed to have the shoe. TMA-A responded that if she could get it laced and on the resident, then they could put him in his chair and not worry about it. On 12/29/15, at 3:57 p.m. R6 seated on side of bed examining the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309		F 309		

Continued From page 47

unlaced shoe. A wellness group was scheduled to begin at 4:00 p.m. On 12/29/15, at 4:17 p.m. R6 was still on the edge of the bed, attempting to re-lace his shoe. This activity had been continuous since 2:30 p.m. or nearly two hours.

R6 was not approached and/or involved in any significant staff to resident communication during the three hour continuous observation on 12/29/15. The resident was handed a sensory object though staff failed to model how object could be used or spend time with the resident. Staff provided minimal interaction with R6 and continually redirected him to his bedroom and eventually put into bed though the resident was wide awake.

R6 was observed on 12/30/15, during the following times:
- At 7:50 a.m. R6 was seated alone at a table in the corner of the dining room eating breakfast independently. The table was pushed flush to the wall on two sides. R6's back was to the other residents as he faced the wall.

- At 7:58 a.m. R6 was assisted in the w/c by staff to the Cityside dayroom and was situated at a table. Staff handed R6 a multicolored cylinder shaped sensory object that also made sound when manipulated. Staff then left the area without further interaction. R6 placed the object behind him on the seat of his w/c and proceeded to propel himself past the nurses' station towards the dining room to the medication cart where LPN-C was standing. Although R6 could not be understood, he vocalized loudly. LPN-C informed R6 he had already eaten and assisted the resident back to his room. LPN-C left the resident's room at 8:05 a.m. R6 was lying on the

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	**12/31/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 309	Continued From page 48	F 309		

bare mattress and pillow without a pillowcase. The bedding was piled at the end of the bed. R6 was holding onto the grab bar, attempting to sit up in bed.

-At 8:25 a.m. R6 was seated at the edge of the bed and the w/c was positioned next to bed with the brakes locked. R6's tennis shoes were located on the seat of the w/c. At 8:36 a.m. R6 was wearing shoes, and was ambulating along the side of the room as he felt the wall. The surveyor alerted the administrator who was walking by to question whether R6 was capable of independent ambulation. The administrator stated R6 did sometimes ambulate, and redirected R6 to his wheelchair. The administrator asked R6 whether he needed his oxygen (O2) as he was heavily breathing. The O2 was applied via a nasal cannula and the administrator left the room.

REVISED

- At 8:49 a.m. R6 removed the 02 tubing, propelled himself from the room via the w/c and entered another resident's room located across the hall. Upon entering the doorway, housekeeping (Hspkg)-A intervened and redirected R6 back to his own room.

-At 10:04 a.m. a church activity was conducted in the activity room. R6 independently propelled himself down the west hallway but once he turned the corner, the administrator redirected and propelled him back down the direction of the hallway. R6 then entered the dayroom, propelling himself around the perimeter of the area, pausing to look out the window and watched the fish in the fish tank. R6 propelled himself toward the direction of the east hallway and remained seated here until 10:30 a.m. LPN-C then moved R6 from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 49	F 309		

Continued From page 49
the east hallway to a table located in the dayroom. No verbal communication nor interaction was noted between staff and R6.

-At 11:07 a.m. R6 was seated in w/c in dayroom by nurses station. A wellness activity in process and was identified on the plan of care as an planned intervention. At 11:27 a.m. R6 was seated in w/c in Cityside dayroom near nurses station when the activity director (AD) entered the dayroom, said "Hi" to R6, turned up the volume on the TV and walked away. At 11:48 a.m. R6 remained seated at the table in the corner of the dining room with his back away from the other residents.

-At 2:16 p.m. NA-B and RN-A attempted to assist R6 to ambulate, however, the resident did not stand when prompted for approximately 30 seconds. The transfer belt was removed and the staff left the resident.

-At 2:35 p.m. R6 was in the dining room where the men's group activity was held in the main area of the dining room. R6 was served a snack while located in the front area of the main dining room, partitioned off by a wall with two openings. R6 was offered his snack at the table where he routinely had been served meals, alone and away from the other residents who were served their snacks in the main dining area. At 2:41 p.m. when R6 finished his snack, propelled himself around the front area of the dining room near his designated table. No staff interacted with R6 until he was assisted out of the dining room towards the direction of his room at 2:44 p.m. When interviewed on 12/30/15, at 12:41 p.m. the AD cited a communication barrier.

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 309	Continued From page 50 When interviewed on 12/20/15, at 3:36 p.m. TMA-A indicated they were unable to communicate with the resident and had not attempted any alternative method, and said it was unfair to R6. TMA-A said R6's family visited approximately monthly. When interviewed on 12/31/15, at 8:50 a.m. the licensed social worker (LSW) and DON stated they were unsure whether R6 would have been able to talk to his family on the telephone. Although they had never attempted to assist him to contact his family, they said it would be worth attempting. When interviewed on 12/31/15, at 1:25 p.m. the DON confirmed the R6 should not have been returned to his room or put into bed when he wandered. The DON stated, "That's sad" when informed the resident had been put into bed with a bare mattress, linen pushed to the end of the bed, and no pillowcase on the pillow. The DON agreed staffs' interventions and/or lack of appropriate interventions were concerning.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		2/8/16

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 325 Continued From page 51

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and document review, the facility failed to ensure interventions were implemented to prevent significant weight loss for 1 of 3 residents (R28) reviewed for nutritional status.

Findings include:

R28's physician order sheet dated 7/1/15, revealed diagnoses including stroke, chronic kidney disease and dementia.

The quarterly Minimum Data Set (MDS), dated 12/11/15 revealed R28 had a weight loss of 5% in the past month or 10% in the past 6 months. The residents current weight at 150#. No chewing or eating problems. The MDS further identified R28 had experienced a weight loss of 20# pound (lb) from the previous MDS dated 9/16/15, of a significant change.

Review of the most current care plan identified R28 as having potential nutritional problems due to dementia and decreased cognition. Interventions listed include: staff assist to set up residents meals, monitor the residents intake and report any changes to the physician, monitor the residents weights and report to the physician any significant weight loss and allow the resident time to eat in a calm setting.

Review of R28's log of weights revealed a 20 lb loss from 170 to 150 lbs. between 9/15 and 12/15 (3 month period).

F 325

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:

1. Resident #28 had his diet reviewed by a licensed dietician and changes made according to his clinical needs.
2. Residents showing weight loss (all residents were reviewed for weight loss) had their dietary needs reviewed by a licensed dietician and any changes made that were necessary to improve their clinical profile with regard to nutrition.
3. Education will be completed on 2-5-16 at an all staff meeting to ensure that interventions are implemented to prevent significant weight loss.
4. The Interdisciplinary Team will meet weekly to review and discuss weight loss and interventions for nutritional services. The dietary manager will document new interventions for nutritional concerns. The MDS Coordinator will do an audit weekly for 2 months to ensure that the nutritional concerns of residents are being followed.
5. The data collected will be reviewed/discussed at the quarterly QA&A

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	**12/31/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 325	Continued From page 52 Review of R28 nutritional assessment dated 10/14/15 indicates the residents weight was at 170#. The resident eats an average 75-100% of his meals and is on a regular diet with no chewing or swallowing problems. Review of R28's mini nutritional assessment dated 12/14/15, with a significant change indicates the residents food intakes are stable and has not declined. The resident is showing a weight loss of 20# in the past 3 months and is at risk for malnutrition. No other information was documented related to causal factors nor interventions related to the weight loss. Review of R28's dietary intakes for the previous 3 months revealed intakes ranging from 0-100% at meals. Average daily intake of food is 25-50%. The residents food intake log revealed the resident had an increased decline in eating for the months of 11/15 and 12/15. R28's most current dietary progress note, completed by the dietician on 12/15/15, indicated the resident's significant weigh loss may be related to the residents increased dementia and requiring more assistance with setting up his meals. No recommendations were provided. During interview with the dietary director (DD) on 12/29/15 at 2:00 p.m., indicated she was unsure of who was responsible for monitoring R28's weights, but confirmed she had completed the most current MDS assessment which triggered/identified R28's significant weight loss. The DD stated R28's weight loss had been discussed with the registered dietician (RD) on 12/15/15, but the RD did not provide any recommendations.	F 325	meeting. At this time the QA&A committee will make the decision/recommendation regarding any follow-up studies. The Dietary Manager and MDS Coordinator will be responsible for this POC. Completion Date: 2-8-16	

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 325	Continued From page 53 During observations of R28 eating breakfast on 12/30/15, at 8:00 a.m. staff were feeding the resident his meal. The resident consumed 90% of his meal but did not participate in the process. The resident received a regular mechanical soft diet with no chewing or swallowing problems. During interview with the facility RD on 12/30/15, at 8:00 a.m. she confirmed she was aware of R28's significant weight loss and stated the nursing staff indicated R28's weight loss was probably due to his dementia and he required more assistance with eating. The RD further included she did not recommend any type of intervention nor recommendation for R28's weight loss due to the residents body mass index (BMI) being within normal ranges. The RD further stated she was not concerned about a residents weight loss if they fall within their BMI, but may follow up the following month. When further questioned, the RD did confirm R28's significant weight loss should have been addressed by the staff for causal factors and follow up interventions.	F 325		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure 1 of 5 rooms (Room 109, R6)	F 465	The preparation of the following plan of correction for this deficiency does not	2/8/16

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 465		F 465		

F 465 Continued From page 54

reviewed with floor or wall damage had bathroom sheet rock that was maintained in good repair.

Findings include:

During observation of bathroom in room 109 (R6) on 12/31/15, at 8:30 a.m. it was noted to have a hole approximately 15 inches by 4 inches in the sheetrock at the base of the bathroom wall which is adjacent to the tub room.

During observation and interview on 12/31/2015, at 8:35 a.m. the maintenance director confirmed the damaged wall in the bathroom of room 109. He stated, "tub has been leaking and this was damaged the resident's wall. He indicated the tub room was adjacent to R6's bathroom. The maintenance director further confirmed a quarter size hole in the wall below the toilet paper dispenser and agreed the areas in the bathroom did not create a homelike environment. The maintenance director could not provide a policy/procedure but indicated staff would fill out a request on the clipboard when there was a problem to be fixed.

F 465 (Provider's Plan of Correction)

constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:

1. Resident #6 bathroom wall was repaired by maintenance.
2. All resident s rooms were observed for damage to walls and repairs made as needed.
3. Education was completed at an all staff meeting on 2-5-16. Staff were informed to notify the maintenance director immediately when they see things that are damaged and need repair and maintenance was in-serviced on the need to provide repairs for the aesthetic enjoyment of the residents.
4. The Maintenance director will do a weekly walk through checking for damage in rooms for 1 month and then bi-monthly for 2 months and then monthly to ensure that the facility does not have any walls in need of repair.
5. The data collected will be reviewed/discussed at the quarterly QA&A meeting. At this time the QA&A committee will make the decision/recommendation regarding any follow-up studies.

The Maintenance Director and Administrator will be responsible for this POC.

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 465	Continued From page 55	F 465	Completion Date: 2-8-16	

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
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: Revised 2567 as a result of an Informal Dispute Resolution, see licensing order 0265. On December 28, 29, 30, and 31 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please	2 000	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.	

REVISED

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/29/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 000	Continued From page 1 sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program; 12 Civic Center Plaza, Suite 2105, Mankato, Minnesota 56001.	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an	2 265		2/8/16

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 265	Continued From page 2	2 265		

attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:

A. an accident involving the resident which results in injury and has the potential for requiring physician intervention;

B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;

C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;

D. a decision to transfer or discharge the resident from the nursing home; or

E. expected and unexpected resident deaths.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to notify the physician in a timely manner for 1 of 4 residents (R46) reviewed for hospitalization who experienced significant changes in condition requiring medical treatment. This resulted in actual harm for R46, who experienced prolonged discomfort, dehydration and vomiting, related to delayed physician notification and subsequent transfer to an inpatient facility for a small bowel obstruction.

Completion Date: 2-8-16

Findings include:

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 265	Continued From page 3	2 265		

R46's discharge orders to the nursing home dated 9/17/15, identified a discharge condition of improving with orders for physical and occupational therapy.

R46's physician's progress notes, dated 9/18/15 indicated diagnoses of spinal stenosis of the lumbar region, sepsis, and urinary tract infection. The physician's progress note also identified a history of diverticulitis of the colon.

R46's admission Minimum Data Set (MDS), dated 9/24/15 identified a Brief Interview for Mental Status score of 13/15 (cognitively intact). No care area assessments were completed with the MDS.

REVISED

R46's care plan, dated 9/30/15 identified no cognitive impairments and that R46 desired to return to the community.

R46's September 2015 medication sheets revealed R46 had received Maalox (an antacid) 30 cubic centimeters (cc)'s on 9/25/15 a total of four times on that date, as well as one dose at 2:00 a.m. on 9/26/15. Notations documented by licensed practical nurse (LPN)-A, on the back of the medication administration record for a dose administered on 9/25/15, at 2:00 a.m. indicated the medication had been given for stomach upset since supper. No follow up assessment for effectiveness was completed. A subsequent entry dated 9/26/15, at 2:00 am. indicated R46 had received another dose of Maalox for an upset stomach and emesis; the follow up result was listed as had another emesis at 4 a.m. None of the other doses administered had follow up results documented.

A nursing progress note written by LPN-F on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ____ B. WING ____	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 265	Continued From page 4	2 265		

9/25/15 at 8:30 a.m., indicated R46 had hiccups and complaints of not feeling well. The notes indicated R46 had been given Maalox 30 cc's along with Thorazine and had begun retching after his morning medications. In addition, R46 had experienced a large projectile emesis all over the bed and himself, and had refused to eat anything for breakfast, stating he had consumed orange juice that had all come up.

A nursing progress note documented by LPN-F on 9/25/15, at 1:39 p.m. indicated R46 had a large emesis, and that the resident had stated he was not feeling well. The notes indicated his hiccups had subsided for a while but had then started again. Documentation indicated R46 had received Maalox and Thorazine (an antipsychotic medication used for antiemetic properties) with another small emesis afterward. The emesis was documented as having had food particles present and was described as having a colicky odor. R46's temperature was documented as having been elevated at 99.0 degrees Fahrenheit (F).

A nursing progress note dated 9/25/15, at 6:00 p.m. per LPN-F indicated R46 had stayed in bed most of the evening. The note indicated R46's hiccups were better over the early evening hours but that R46 had been stated his tummy still didn't feel right and that whenever he moved he began to gag. R46 had eaten Jell-O for supper and had sips of water. Additionally, the documentation indicated a fax (facsimile) had been sent to medical doctor (MD)-A with an update on R46's condition including that R46 had an elevated temperature at 99.5 degrees F and complained of feeling chilly.

A nursing progress note dated 9/25/15, at 11:05 p.m. per LPN-F indicated R46 had not been

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 265	Continued From page 5	2 265		

feeling well, and had been having brown colored emesis twice on the afternoon shift which did not appear to have a feces odor. Maalox 30 cc's had been given to help with hiccups and R46's vitamins had been held due to emesis.

A nursing progress note by LPN-A, dated 9/26/15, at 1:56 a.m. indicated R46's abdomen was distended, his bowel sounds were difficult to hear and he had been having emesis which looked like BM. R46's temp was noted to be slightly elevated at 99.1 degrees F.

A nursing progress note written by LPN-A on 9/26/15, at 4:48 a.m. indicated R46 had 100 cc's of emesis, like soft formed/loose BM (bowel movement) with no odor. The note further indicated R46 was cool and clammy, with a slightly elevated temperature at 99.1 degrees F. R46 had a wastebasket beside him, and continued to wretch.

A nursing progress note entered by LPN-B, dated 9/26/15, at 9:57 a.m. indicated R46 had two further emesis of greenish liquid thick with pieces of BM looking in it. In addition, the note indicated an acute care hospital had been called and an order was received to transfer R46 to their emergency room (ER) via ambulance. The note indicated R46's daughter was updated and had agreed to meet him at the hospital. R46 left the facility at 8:45 a.m.

A faxed physician's order dated 9/26/15 was present in R46's record and verified the physician order to transfer per ambulance to the acute care hospital.

An additional nursing progress note dated 9/26/15, at 2:06 p.m. indicated R46 had been

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 265	Continued From page 6	2 265		

admitted to the acute care hospital with a diagnoses of bowel obstruction, and would need surgery.

A faxed physician's order sent on 9/25/15, at 6:05 p.m. from the facility to R46's primary physician identified that R46 had emesis since 8:30 a.m., experienced several rounds of hiccups throughout the day and had been unable to eat or drink. R46 complained of feeling weak. The fax had not been signed off until on 9/28/15, three days later, when the nurse practitioner (NP)-A responded with a statement including, "Noting telephone order to transfer to ER on 9/26/15. Please do NOT fax in regard to situations that need attn [attention] that day. This will be sent to [physician] - today 9/28/15. Please review the faxing for response procedure. Thx [Thanks]."

The ER progress note dated 9/26/15, at 10:36 a.m. was reviewed. The ER note indicated R46 had appeared distressed when examined, had been uncomfortable, and had dry oral mucous with dried brown material on the tongue and lips. The ER note further indicated R46's abdomen was firm and diffusely distended, mildly tender with no appreciable bowel sounds. In addition, 1800 milliliters (ml) of brown liquid had been drained from R46's stomach after the insertion of a nasogastric tube. R46 had received 2000 ml of normal saline intravenous for hydration. The ER physician's note indicated R46 had appeared quite dehydrated and verified the admitting diagnoses of small bowel obstruction and severe dehydration.

The ER registered nurse's assessment dated 9/26/15, at 11:17 a.m. indicated: R46 had stated he'd been vomiting for the last two days and his emesis was now brown like stool. R46 had

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 265	Continued From page 7	2 265		

vomited three times in the ambulance enroute to the ER and the vomit was described as dark brown liquid running out of his mouth. R46's abdomen was very firm, with no bowel sounds and the abdomen was distended. R46 complained of abdominal pain but was unable to rate the pain. R46 had his stomach drained via a nasogastric tube for ten minutes with 1400 mL of fluid output after which R46 stated he felt much better. R46 was alert and "states we should do what ever we have to do. Is comfortable now."

The hospital discharge summary dated 10/5/15, indicated R46 had undergone abdominal surgery to correct the small bowel obstruction, and had developed subsequent cardiac and anticoagulation issues as well as post-operative ileus (disruption in normal bowel motility) after the surgery. The ileus resolved with the replacement of a nasogastric tube; however, comfort cares were initiated and R46 passed away on 10/5/15.

During interview on 12/29/15, at 3:07 p.m. the director of nursing (DON) verified she would have expected staff to contact the on-call doctor immediately with the urgent clinical issues, especially when the resident was vomiting BM-type material and not feeling better.

During interview on 12/29/15, at 3:32 p.m. the nursing home's health information coordinator/nursing scheduler (HIM) stated LPN-B was not well and was currently in a hospital intensive care unit, unavailable for interview. The HIM verified LPN-F had been a pool nursing staff.

During interview on 12/29/15, at 3:45 p.m. the acting administrator, who had been the DON at the time of the incident stated she'd thought

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 265	Continued From page 8 R46's family had indicated he was admitted to the hospital with a bowel obstruction, but that it had later been found to be a narrowed bowel. The administrator was unable to recall specifics regarding R46's episode of illness; however, stated she would have expected staff to contact/call the on-call and/or primary physician directly with concerns that were urgent. The administrator stated she would have expected the staff to check the vital signs, bowel movement status, appetite and fever status while conducting a physical assessment. The administrator stated she thought LPN-A was a good nurse and trusted her judgment. She further verified LPN-A worked every Thursday night shift. When LPN-A was interviewed about the incident on 12/29/15 at 4:02 p.m., LPN-A stated she'd received report from the evening nurse (LPN-F) on 9/25/15, regarding R46's emesis, but had been unaware a fax had been sent. LPN-A stated she'd worked with R46 at least one time prior and was aware R46's vomiting and complaints of not feeling well was new for R46. She was aware R46 had thrown up and had not been eating well, and had subsequently administered Maalox during the night. LPN-A thought the Maalox had helped somewhat the first time she administered it (around 2:00 a.m.). LPN-A verified R46 had emesis of what looked like stool but there was no odor. She verified his abdomen had also seemed a little distended. LPN-A was unaware whether R46 had complained of pain. LPN-A said R46 subsequently vomited and it looked more like BM later in her shift (around 5:00 a.m.) at which time she'd become concerned that he may have something wrong with his small bowel. LPN-A said she'd proceeded to fill out all the transfer paperwork for a hospital discharge; however, did	2 265		

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 265	Continued From page 9 not call the RN on call nor notify the physician of her concern. LPN-A indicated she had passed along the paperwork and her concern to the day nurse, LPN-B, who arrived on duty at 6:00 a.m. on 9/26/25. LPN-A stated she'd told LPN-B to do an assessment to follow up on R46's condition. During the interview, LPN-A stated she thought there had been a history of small bowel concerns she had noted when filling out the paperwork to pass along to the day shift personnel. During a follow up interview on 12/30/15, at 9:12 a.m. the administrator stated LPN-A should have notified the physician sooner about R46's symptoms, and that she had not been aware there had been a delay in his nursing care and physician notification of his condition. During interview on 12/30/15, at 2:11 p.m. the medical director was interviewed and stated she would have expected nursing staff to call when they filled out the paperwork to transfer R46 to the hospital. The medical director stated although R46 may have subsequently expired anyway, prompt medical care would have made him comfortable. The medical director stated the effect of delayed medical care/interventions related to R46's medical outcome was difficult to state since she was not his usual physician. During interview on 12/31/15, at 9:27 a.m. medical doctor (MD)-A (R46's usual physician) stated he would have expected staff to have called the clinic and/or the on-call physician when R46 began vomiting stool-like material. MD-A stated faxing medical staff at the clinic at 6:00 p.m. was inappropriate as the fax machine was not attended at that time of day. MD-A stated he'd been concerned about the potential for ischemic bowel when R46 arrived at the hospital,	2 265		

REVISED

(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) COMPLETE DATE
2 265	Continued From page 10	2 265		

due to the delay in receipt of medical attention after his symptoms began. MD-A stated R46 had made some "depressed" comments prior to the hospital transfer on 9/26/15, but those comments were a "sidebar" and were not relevant to this issue. MD-A confirmed R46 would have been more comfortable if he had been examined sooner in the ER. MD-A stated, "when you are vomiting brown stuff, it is probably a good idea if you are seen."

The facility's policy entitled Change in Condition SBAR last revised 3/15, indicated immediate notification of the physician was required for any symptom, sign or apparent discomfort that was sudden in onset, a marked change (i.e. more severe) in relation to usual signs and symptoms and was unrelieved by measures already prescribed. The policy further indicated in a section related to abdominal distension that immediate notification of the physician was required when there was rapid onset, or presence of marked tenderness, fever, vomiting or GI (gastrointestinal) bleeding.

REVISED

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility notifies the physician in a timely manner when the resident's condition changes and according to individualized needs. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance and review findings at the quarterly QA&A meetings.

TIME PERIOD FOR CORRECTION: Twenty-one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	**12/31/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 265	Continued From page 11 (21) days.	2 265		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide to residents and/or interested family members information regarding:	2 302	Completion Date: 2-8-16	2/8/16

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 302	Continued From page 12 Alzheimer's training staff received, who received training, how often, and a description of the training provided. This had the potential to affect all current residents of the facility and their families. Findings include: A review of the Alzheimer's training program consists of all required elements, staff are trained in care of the cognitively impaired on new hire and do an additional module each quarter related to an aspect of Alzheimer's care. During review of admission forms and documents provided to residents and their families upon admission to the facility indicated there was no information regarding Alzheimer's training. During an interview on 12/30/15, at 3:15 p.m. the director of nursing (DON) stated she reviewed the information with the administrator and verified they are not providing written information to consumers related to Alzheimer's training indicating they will start "working on it". SUGGESTED METHOD OF CORRECTION: The DON or designee could review their policies and procedures in addition to insuring updated information is being provided to residents and/or their families regarding Alzheimer's/Dementia training. Provision of training/notification could then be reviewed at the quarterly QA&A meeting. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 302		

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 565	Continued From page 13	2 565		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care related to activities for 2 of 3 (R6, R23) residents reviewed for activities. Findings include: When interviewed on 12/29/15, at approximately 8:50 a.m. the director of nursing (DON) confirmed R6 did not speak or understand English. DON further indicated staff communicated with the resident through gestures and facial expressions. R6 was admitted to the facility on 9/5/14, with diagnoses including dementia without behavioral disturbance, cognitive communication deficit, chronic obstructive pulmonary disease (COPD), muscle weakness and difficulty walking per the facility diagnosis report. R6's care plan for activities dated 10/12/15, indicated the resident was primarily independent but occasionally needed some guidance with structuring leisure activities that promote wellness. Interventions identified on the care plan: (1.) CD player in room; please play music per resident's desire.	2 565	Completion Date: 2-8-16	2/8/16

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 565		2 565		

Continued From page 14

(2.) Recreation/Wellness preferences include: exercise, listening to music, watching TV (enjoys wrestling and war movies) food related activities, sensory and 1:1 time.
(3.) EMOTIONAL: Offer ipod or CD player for individual music enjoyment.
(4.) PHYSICAL: Encourage participation in Well-Fit program to include group exercise and/or individual cardio. The activity goal indicated R6 would work on puzzles in day room by the review period.

On 12/29/15, R6 was observed continuously from 1:16 p.m. until 4:17 p.m.

- At 1:16 p.m. R6 was ambulated with the assistance of two staff, a third staff pushed the residents wheelchair (w/c) behind him down the west cityside hallway. After R6 ambulated the length of the hall staff seated him back in the w/c, removed the transfer belt and transferred him to the dayroom area located by the nurses' station. Staff moved him in front to the television and then R6 propelled himself in the w/c throughout the dayroom.

-At 1:27 a.m. nursing assistant (NA)-A brought R6 a round shaped sensory item which consisted of multiple-colored hollow tubes held together with a bungy type cord. This enabled the object to be stretched and manipulated. R6 accepted the item, talking out loud constantly. Although R6 held the item, he did not appear interested nor did he attempt to manipulate or pull the sensory item. NA-A left the area after the item was delivered to R6.

-At 1:34 p.m. a staff member transported R6 from the middle of the dayroom to a table with another resident. R6 continued to verbalize while the

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 565	Continued From page 15	2 565		

sensory object remained on his lap. No interaction between staff and R6 occurred. R6 remained at the table a short time and then began to propel the w/c around the dayroom.

-At 2:00 p.m., R6 was observed lying in bed on top of covers with shoes on. The sensory item given to him earlier was placed on his legs. R6 was not touching nor handling the item even though he appeared to be wide awake. At this time, a popcorn and movie activity was occurring in the activity room.

-At 2:07 p.m. it was noted that R6 was sitting up on edge of bed with feet dangling down, the sensory item remained on resident's lap. It was again noted that R6 was not touching nor interested in this sensory object.

REVISED

-At 2:14 p.m. staff entered the room to distribute fresh water, greeted R6 and left immediately.

-At 2:30 p.m., R6 was seated on the edge of his bed in room with the left shoe off and was holding a shoe on his lap, removing the laces. The sensory object was no longer visualized. No music was playing in the room.

-At 2:39 p.m., R6 remained seated at the edge of the bed attempting to pull the laces from his left shoe. R6 had a nebulizer mask on and no staff were present in the room during this observation. Coffee social and word games activities were held in the dining room at this time.

-At approximately 2:50 p.m., LPN-D in R6's room attending to the nebulizer machine while R6 continued to sit on edge of bed attempting to remove the laces from his left shoe. At 2:56 p.m. R6 remained seated at the edge of bed holding

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 565	Continued From page 16	2 565		

onto the unlaces left shoe. At 3:10 p.m. NA-C entered the room and greeted R6. Trained medication aide (TMA)-A also entered the room and asked whether R6 was still "working on his shoe". NA-C asked TMA-A whether R6 was supposed to have the shoe. TMA-A responded that if NA-C could get it laced and on R6, they could transfer him into his chair and not worry about it. On 12/29/15, at 3:57 p.m. R6 remained seated on the side of bed, holding his left shoe without laces. R6 appeared to be examining the shoe. The Wellness group was on the activity schedule for 4:00 p.m. At 4:17 p.m. R6 remained seated on edge of bed, holding onto the left shoe and was attempting to replace the laces back in the shoe. This activity had been continuous since 2:30 p.m. (almost 2 hours).

R6 was not offered/assisted to scheduled activities during the 3 hours of continuous observation on 12/29/15. The plan of care was not followed as written. R6 was handed a sensory object though staff failed to model how object could be used and/or spend time any time with R6.

It was observed on 12/30/15, at 10:04 a.m. a church activity was conducted in the activity room. R6 independently propelled himself down the west hallway but once R6 turned the corned, the administrator redirected and propelled him back down the direction of the hallway. R6 then entered the dayroom, propelling self around the perimeter of the area, pausing to look out the window and then watched the activity in the fish tank. R6 propelled self toward the direction of the east hallway and remained seated near this area until 10:30 a.m. LPN-C then moved R6 from the east hallway to a table located in the dayroom. No verbal communication nor interaction was

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER: **VALLEY VIEW MANOR HCC**

STREET ADDRESS, CITY, STATE, ZIP CODE: **200 EAST NINTH AVENUE, LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 565	Continued From page 17	2 565		

noted between staff and R6. R6 was not offered/assisted to the church activity at anytime throughout the noted observations nor did staff interact with the resident.

On 12/30/15, at 11:07 a.m. R6 was observed seated in w/c in dayroom by nurses station; Wellness activity was currently in process and was identified on the plan of care as an planned intervention.

At 11:27 a.m. R6 was seated in w/c in cityside dayroom near nurses station when the activity director (AD) entered the dayroom, said "Hi" to R6, turned up the volume on the TV and walked away. At 2:35 p.m. R6 was observed in the dining room where the men's group activity was held in the main area of the dining room. R6 was served a snack while located in the front area of the main dining room, partitioned off by a wall with 2 openings. R6 was offered his snack at the table where he routinely consumed his meals. R6 was left alone in the front area of the dining room while the other residents were served their snack in the main area. At 2:41 p.m. when R6 finished his snack, propelled himself around the front area of the dining room near his designated table. No activity staff were noted to interact with R6 until they assisted out of the dining room towards the direction of his room at 2:44 p.m.

When interviewed on 12/30/15, at 12:41 p.m. the AD stated R6 is very "antsy" r/t group activities and is scheduled for in-room programming. AD further indicated that 2 in-room activity programs were scheduled for 20 minutes/day. AD also stated staff will also offer coffee social time as well as the men's group activity as well as three 1:1 visits weekly.
When questioned about the preferred activities

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 565	Continued From page 18	2 565		

(wrestling and war movies) documented on R6's care plan, she indicated being unaware of these preferences. When the current activity sheets were reviewed to substantiate the activities each resident had attended, there was nothing highlighted and/or documented indicating that R6 had been involved in activities during the days of observations.

When further interviewed on 12/31/15, at 10:21 a.m. the AD provided 10 days of December 2015 activity sheets which indicated R6 was offered activities on 8 of the 10 days. AD stated the activity sheet dated 12/21/15, indicated the resident was offered the exercise activity. AD stated she sat next to R6 during the activity and he did really well. However, the AD was unable to provide documentation of activities offered in November 2015 and provided 5 days of activity sheets for October 2015. It was confirmed the plan of care was not implemented as written.

REVISED

R23 was admitted on 1/6/15 with diagnoses including: dementia, paranoid personality, mood disorder, and chronic obstructive pulmonary disease (COPD) per the facility diagnosis report. The report further identified R23 was admitted to hospice services on 5/15/15 due to senile degeneration of the brain.

R23's care plan last revised 11/9/15, indicated the resident was dependent on staff for structuring and providing activities that promote wellness stimulation due to cognitive deficits. Interventions included: (1) "1 to 1 bedside/in-room visits and activities if [resident name] is unable to attend out of room events. (2) COGNITIVE: Encourage participation in small groups and/or 1:1 interactions (3) EMOTIONAL: Offer ipod or CD player for individual music enjoyment. (4)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 565	Continued From page 19 ENVIRONMENTAL: Observe [resident name] body language related to overstimulation [Resident name] Recreation/Wellness individual preferences include Bingo, walks, magazines, word search, TV and listening and playing music." R23 was observed continuously on 12/29/15, from 1:14 p.m. until 3:56 p.m. while lying in bed. A popcorn and move activity was held at 1:30 p.m. in the activity room and the coffee social activity held at 2:30 p.m. in the dining room. Staff did not offer R23 the opportunity to attend either activity. R23 was again observed continuously on 12/30/15, from 10:03 a.m. until 10:23 a.m. At 10:03 a.m. R23 was seated in a geri chair in the cityside dayroom at a table while a church service was currently being held in the activity room. At 10:21 a.m. R23 remained in the geri-chair with eyes closed. The AD approached another resident seated in w/c located near the cityside nurses station and asked whether she wanted to attend church. R23 opened her eyes when the AD and the resident left for church but looked away and closed her eyes when they left the area. NA-A then approached R23 at 10:23 a.m. to ask whether she wanted to lay down; R23 nodded "yes". NA-A did not give her the opportunity to attend the church activity before transporting her to her room. At 11:08 a.m. R23 was observed lying in bed with eyes closed while a Wellness activity was in process. She had not been given the opportunity to attend this activity. At 3:12 p.m. R23 was again lying in bed with eyes closed. A music activity was being performed in	2 565		

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 565	Continued From page 20 the cityside dayroom with a resident's family member piano playing. Staff were not observed to offer attendance to the activity to R23. When interviewed on 12/30/15, at 11:55 a.m. NA-B and NA-A confirmed they had assisted R23 with her morning cares, stating that when offered activities, she often refuses as prefers to lie down. Both NA's confirmed they had not offered R23 attendance at the morning church activity as R23 had been tearful that morning when receiving care and they felt the resident would rather lie down. When interviewed on 12/30/15, at 1:40 p.m. the AD stated R23's activities included hair care, a daily Sunshine group (sensory group) which is implemented twice daily Monday-Friday and once on Saturdays). AD confirmed she would still expect R23 be offered the opportunity to participate in attending church. AD attempted to located documentation of activities attended and 1:1's provided for R23. The 1:1 activity sheets indicated R23 was to have 1:1's three times/weekly. AD provided 1:1 documentation from 11/2/15 - 12/5/15 (minus the week of 11/16/15 - 11/22/15); R23 was provided a 1:1 on 7 occasions during this period (11/5/15, 11/7/15, 11/12/15, 11/13/15, 11/27/15, 12/4/15, 12/7/15). When interviewed on 12/31/15, at 10:21 a.m. the AD provided 10 days of December 2015 activity sheets for 23. The sheets indicated R23 was offered activities on 5 of the 10 days. AD was unable to provide documentation of activities offered in November 2015 and provided 5 days of activity sheets for October 2015. The activity sheets did not include evidence if the resident had participated or refused the activity; AD confirmed the charting of activities was	2 565		

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 565	Continued From page 21 incomplete. The plan of care was not implemented as written. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility develops care plans according to the residents individualized needs. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. The results of these audits could then be presented at the quarterly QA&A meetings. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		
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 by:	2 830		2/8/16

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ________ B. WING ________	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 830	Continued From page 22	2 830		

Continued From page 22

Based on interview and document review, the facility failed to provide adequate nursing care and services for 2 of 4 residents (R46, R21) reviewed who had been hospitalized. This resulted in actual harm for R46, who experienced prolonged discomfort, dehydration and vomiting related to delayed nursing assessment and transfer to an inpatient facility for a small bowel obstruction. In addition, the facility failed to provide appropriate interventions related to dementia care for 1 of 1 resident (R6) reviewed who had dementia and could not speak/understand English.

Completion Date: 2-8-16

Findings include:

R46's discharge orders to the nursing home dated 9/17/15, identified a discharge condition of improving with orders for physical and occupational therapy.

R46's physician's progress notes, dated 9/18/15 indicated diagnoses of spinal stenosis of the lumbar region, sepsis, and urinary tract infection. The physician's progress note also identified a history of diverticulitis of the colon.

R46's admission Minimum Data Set (MDS), dated 9/24/15 identified a Brief Interview for Mental Status score of 13/15 (cognitively intact). No care area assessments were completed with the MDS.

R46's care plan, dated 9/30/15 identified no cognitive impairments and that R46 desired to return to the community.

R46's September 2015 medication sheets revealed R46 had received Maalox (an antacid) 30 cubic centimeters (cc)'s on 9/25/15 a total of four times on that date, as well as one dose at

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 23	2 830		

2:00 a.m. on 9/26/15. Notations documented by licensed practical nurse (LPN)-A, on the back of the medication administration record for a dose administered on 9/25/15, at 2:00 a.m. indicated the medication had been given for stomach upset since supper. No follow up assessment for effectiveness was completed. A subsequent entry dated 9/26/15, at 2:00 am. indicated R46 had received another dose of Maalox for an upset stomach and emesis; the follow up result was listed as had another emesis at 4 a.m. None of the other doses administered had follow up results documented.

A nursing progress note written by LPN-F on 9/25/15 at 8:30 a.m., indicated R46 had hiccups and complaints of not feeling well. The notes indicated R46 had been given Maalox 30 cc's along with Thorazine and had begun retching after his morning medications. In addition, R46 had experienced a large projectile emesis all over the bed and himself, and had refused to eat anything for breakfast, stating he had consumed orange juice that had all come up.

A nursing progress note documented by LPN-F on 9/25/15, at 1:39 p.m. indicated R46 had a large emesis, and that the resident had stated he was not feeling well. The notes indicated his hiccups had subsided for a while but had then started again. Documentation indicated R46 had received Maalox and Thorazine (an antipsychotic medication used for antiemetic properties) with another small emesis afterward. The emesis was documented as having had food particles present and was described as having a colicky odor. R46's temperature was documented as having been elevated at 99.0 degrees Fahrenheit (F).

A nursing progress note dated 9/25/15, at 6:00

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 24	2 830		

p.m. per LPN-F indicated R46 had stayed in bed most of the evening. The note indicated R46's hiccups were better over the early evening hours but that R46 had been stated his tummy still didn't feel right and that whenever he moved he began to gag. R46 had eaten Jell-O for supper and had sips of water. Additionally, the documentation indicated a fax (facsimile) had been sent to medical doctor (MD)-A with an update on R46's condition including that R46 had an elevated temperature at 99.5 degrees F and complained of feeling chilly.

A nursing progress note dated 9/25/15, at 11:05 p.m. per LPN-F indicated R46 had not been feeling well, and had been having brown colored emesis twice on the afternoon shift which did not appear to have a feces odor. Maalox 30 cc's had been given to help with hiccups and R46's vitamins had been held due to emesis.

REVISED

A nursing progress note by LPN-A, dated 9/26/15, at 1:56 a.m. indicated R46's abdomen was distended, his bowel sounds were difficult to hear and he had been having emesis which looked like BM. R46's temp was noted to be slightly elevated at 99.1 degrees F.

A nursing progress note written by LPN-A on 9/26/15, at 4:48 a.m. indicated R46 had 100 cc's of emesis, like soft formed/loose BM (bowel movement) with no odor. The note further indicated R46 was cool and clammy, with a slightly elevated temperature at 99.1 degrees F. R46 had a wastebasket beside him, and continued to wretch.

A nursing progress note entered by LPN-B, dated 9/26/15, at 9:57 a.m. indicated R46 had two further emesis of greenish liquid thick with pieces

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ________ B. WING ________	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 830	Continued From page 25	2 830		

of BM looking in it. In addition, the note indicated an acute care hospital had been called and an order was received to transfer R46 to their emergency room (ER) via ambulance. The note indicated R46's daughter was updated and had agreed to meet him at the hospital. R46 left the facility at 8:45 a.m.

A faxed physician's order dated 9/26/15 was present in R46's record and verified the physician order to transfer per ambulance to the acute care hospital.

An additional nursing progress note dated 9/26/15, at 2:06 p.m. indicated R46 had been admitted to the acute care hospital with a diagnoses of bowel obstruction, and would need surgery.

A faxed physician's order sent on 9/25/15, at 6:05 p.m. from the facility to R46's primary physician identified that R46 had emesis since 8:30 a.m., experienced several rounds of hiccups throughout the day and had been unable to eat or drink. R46 complained of feeling weak. The fax had not been signed off until on 9/28/15, three days later, when the nurse practitioner (NP)-A responded with a statement including, "Noting telephone order to transfer to ER on 9/26/15. Please do NOT fax in regard to situations that need attn [attention] that day. This will be sent to [physician] - today 9/28/15. Please review the faxing for response procedure. Thx [Thanks]."

The ER progress note dated 9/26/15, at 10:36 a.m. was reviewed. The ER note indicated R46 had appeared distressed when examined, had been uncomfortable, and had dry oral mucous with dried brown material on the tongue and lips. The ER note further indicated R46's abdomen

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 830	Continued From page 26	2 830		

Continued From page 26

was firm and diffusely distended, mildly tender with no appreciable bowel sounds. In addition, 1800 milliliters (ml) of brown liquid had been drained from R46's stomach after the insertion of a nasogastric tube. R46 had received 2000 ml of normal saline intravenous for hydration. The ER physician's note indicated R46 had appeared quite dehydrated and verified the admitting diagnoses of small bowel obstruction and severe dehydration.

The ER registered nurse's assessment dated 9/26/15, at 11:17 a.m. indicated: R46 had stated he'd been vomiting for the last two days and his emesis was now brown like stool. R46 had vomited three times in the ambulance enroute to the ER and the vomit was described as dark brown liquid running out of his mouth. R46's abdomen was very firm, with no bowel sounds and the abdomen was distended. R46 complained of abdominal pain but was unable to rate the pain. R46 had his stomach drained via a nasogastric tube for ten minutes with 1400 mL of fluid output after which R46 stated he felt much better. R46 was alert and "states we should do what ever we have to do. Is comfortable now."

REVISED

The hospital discharge summary dated 10/5/15, indicated R46 had undergone abdominal surgery to correct the small bowel obstruction, and had developed subsequent cardiac and anticoagulation issues as well as post-operative ileus (disruption in normal bowel motility) after the surgery. The ileus resolved with the replacement of a nasogastric tube; however, comfort cares were initiated and R46 passed away on 10/5/15.

During interview on 12/29/15, at 3:07 p.m. the director of nursing (DON) verified she would have expected staff to contact the on-call doctor

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	**12/31/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 830	Continued From page 27	2 830		

immediately with the urgent clinical issues, especially when the resident was vomiting BM-type material and not feeling better.

During interview on 12/29/15, at 3:32 p.m. the nursing home's health information coordinator/nursing scheduler (HIM) stated LPN-B was not well and was currently in a hospital intensive care unit, unavailable for interview. The HIM verified LPN-F had been a pool nursing staff.

During interview on 12/29/15, at 3:45 p.m. the acting administrator, who had been the DON at the time of the incident stated she'd thought R46's family had indicated he was admitted to the hospital with a bowel obstruction but that it had later been found to be a narrowed bowel. The administrator was unable to recall specifics regarding R46's episode of illness; however, stated she would have expected staff to contact/call the on-call and/or primary physician directly with concerns that were urgent. The administrator stated she would have expected the staff to check the vital signs, bowel movement status, appetite and fever status while conducting a physical assessment. The administrator stated she thought LPN-A was a good nurse and trusted her judgment. She further verified LPN-A worked every Thursday night shift.

When LPN-A was interviewed about the incident on 12/29/15 at 4:02 p.m., LPN-A stated she'd received report from the evening nurse (LPN-F) on 9/25/15, regarding R46's emesis, but had been unaware a fax had been sent. LPN-A stated she'd worked with R46 at least one time prior and was aware R46's vomiting and complaints of not feeling well was new for R46. She was aware R46 had thrown up and had not

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 28 been eating well, and had subsequently administered Maalox during the night. LPN-A thought the Maalox had helped somewhat the first time she administered it (around 2:00 a.m.). LPN-A verified R46 had emesis of what looked like stool but there was no odor. She verified his abdomen had also seemed a little distended. LPN-A was unaware whether R46 had complained of pain. LPN-A said R46 subsequently vomited and it looked more like BM later in her shift (around 5:00 a.m.) at which time she'd become concerned that he may have something wrong with his small bowel. LPN-A said she'd proceeded to fill out all the transfer paperwork for a hospital discharge, however, did not call the RN on call nor notify the physician of her concern. LPN-A indicated she had passed along the paperwork and her concern to the day nurse, LPN-B, who arrived on duty at 6:00 a.m. on 9/26/25. LPN-A stated she'd told LPN-B to do an assessment to follow up on R46's condition. During the interview, LPN-A stated she thought there had been a history of small bowel concerns she had noted when filling out the paperwork to pass along to the day shift personnel. During a follow up interview on 12/30/15, at 9:12 a.m. the administrator stated LPN-A should have notified the physician sooner about R46's symptoms, and that she had not been aware there had been a delay in his nursing care and physician notification of his condition. During interview on 12/30/15, at 2:11 p.m. the medical director was interviewed and stated she would have expected nursing staff to call when they filled out the paperwork to transfer R46 to the hospital. The medical director stated although R46 may have subsequently expired anyway, prompt medical care would have made	2 830		

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 29	2 830		

him comfortable. The medical director stated the effect of delayed medical care/interventions related to R46's medical outcome was difficult to state since she was not his usual physician.

During interview on 12/31/15, at 9:27 a.m. medical doctor (MD)-A (R46's usual physician) stated he would have expected staff to have called the clinic and/or the on-call physician when R46 began vomiting stool-like material. MD-A stated faxing medical staff at the clinic at 6:00 p.m. was inappropriate as the fax machine was not attended at that time of day. MD-A stated he'd been concerned about the potential for ischemic bowel when R46 arrived at the hospital, due to the delay in receipt of medical attention after his symptoms began. MD-A stated R46 had made some "depressed" comments prior to the hospital transfer on 9/26/15, but those comments were a "sidebar" and were not relevant to this issue. MD-A confirmed R46 would have been more comfortable if he had been examined sooner in the ER. MD-A stated, "when you are vomiting brown stuff, it is probably a good idea if you are seen."

The facility's policy entitled Change in Condition SBAR last revised 3/15, indicated immediate notification of the physician was required for any symptom, sign or apparent discomfort that was sudden in onset, a marked change (i.e. more severe) in relation to usual signs and symptoms and was unrelieved by measures already prescribed. The policy further indicated in a section related to abdominal distension that immediate notification of the physician was required when there was rapid onset, or presence of marked tenderness, fever, vomiting or GI (gastrointestinal) bleeding.

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 30	2 830		

Review of R21's Medication Administration Record (MAR) dated December 2015, identified that blood sugar (BS) readings were monitored five (5) times per day. Between the dates of 12/1 - 12/29/15 there were 44 blood sugar (BS) levels which were documented as 400 milligrams (mg)/ deciliter (dL) and above, with 25 of those documented BS level readings higher than 430 mg/dL. Although the resident's blood sugars fluctuated dramatically, there had not been physician notification of blood sugars which registered greater than 430 mg/dL.

A physician's order, dated 11/3/15 indicated, Insulin Regular Human Solution 100 unit/milliliter (ml) Inject as per sliding scale with the final ordered dosage "greater than 400 mg/dL: give 6 units".

A physician's order, dated 12/7/15 indicated, Insulin Glargine Solution 100 unit/ml- 24 units subcutaneous (SQ) one time per day (QD), and sliding scale with Regular Humalog solution 100 unit/ml. BS readings were to be faxed to the diabetic educator weekly. No parameters were listed for notification of the physician regarding hypo (low) or hyper (high) glycemia (BS).

During interview on 12/30/15, at 3:10 p.m. a licensed practical nurse (LPN)-C indicated there were no protocols, or orders, indicating when to notify the medical doctor (MD) of BS levels. LPN-C stated she would notify the MD related to how the resident felt and if there was a high BS-which she identified as "way above 400's-500's".

On 12/30/15, at 2:36 p.m. LPN-D stated she would notify the MD if she obtained a BS result above 600 mg/dL. LPN-D confirmed on

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 830	Continued From page 31 12/29/15, the supper BS check for R21 was 521 mg/dL and the MD was not updated. LPN-D further stated R21 frequently has BS readings above 400 mg/dL and the facility standing orders read to give 6 units of regular insulin if the BS was greater than 350 mg/dL. LPN-D indicated when the glucometer read "high" it was the result of a BS over 600 mg/dL and she would telephone the nurse on call at the hospital to report the reading. During interview on 12/30/15, at 2:57 p.m. the diabetic educator indicated she received weekly reports of R21's BS results. She further stated the clinic has a protocol for diabetic medication adjustments and this was what insulin changes were based upon. The diabetic educator further stated R21 had a history of being a brittle diabetic and nursing staff were supposed to call the medical provider on call and/or the triage nurse related to changes in status. The diabetic educator further indicated she thought BS parameters had been identified when R21 was recently discharged from the the hospital on 12/5/15. She indicated the parameters would have been determined by the discharging MD. During interview on 12/30/15, at 3:12 p.m. RN-B and RN-C stated there were facility parameters for reporting BS readings. They referenced the documentation on the facility's standing orders and stated that would be the practice they followed unless individualized orders were written. RN-B indicated if a resident was symptomatic she would notify the physician based on the standing order instructions. RN -B and RN-C indicated they were not aware of the Change in Condition policy related to immediate reporting of BS readings above 430 mg/DL. RN-B stated, "we will have to make certain	2 830		

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 32	2 830		

everyone is aware of this policy".

During interview on 12/31/15, at 8:36 a.m. LPN-E indicated she had been employed as an LPN for 3 months at the facility and had received training on BS checks which included: to test in a private area, wear gloves, and follow MD orders if the resident had orders for a sliding scale (SS), or a specific insulin order. LPN-E stated if there was a "high" reading she would contact the MD on call for direction. In the instance of a 400+ reading for R21 LPN-E indicated she would administer the ordered SS dose and recheck in one hour and then recheck in the following hour to determine whether the BS was responding to insulin. LPN-E stated she would probably not notify the MD in this instance as this resident has a history of BS fluctuations. LPN-E further indicated R21 did not have specific orders for follow up but this is what she would do.

On 12/31/15, at 9:04 a.m. R21's physician, also the facility's medical director, stated typically a resident would have a specific order that comes from the hospital for sliding scale insulin. R21's physician stated R21 had been her patient even before admission to the nursing home, and had a history of blood sugars fluctuating "all over" but that the resident was usually most comfortable when her blood sugars ran over 300 mg/dl. However, stated if she'd received a telephone call for an elevated blood sugar level she could provide specific orders as to when staff were required to recheck the BS and call back the results. She stated, "they call if the meter reads 'hi' because they have nothing to base it off. If the blood sugar is below 70 mg/dL staff would need to initiate the hypoglycemia protocol." She further indicated she would expect staff to notify the clinic and/or on-call staff to update on BS readings that

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 33 were outside range. When interviewed on 12/31/15, at 1:00 p.m. the director of nursing (DON) reviewed the December 2015 documentation of R21's BS readings and indicated she was unaware of the wide fluctuation of BS readings for R21 which were over 430 mg/dL. She confirmed she would have expected staff to notify the attending MD and/or the on-call staff in accordance with the Change in Condition When to Report to the MD/NP/PA policy. The facility's policy related to physician notification for blood sugar fluctuations, entitled, Change in Condition When to Report to the MD/nurse practitioner (NP)/physician assistant last revised 3/15, included "blood sugars greater than 430 mg/dL (or machine registers high) in diabetic patients using sliding scale insulin should be immediately reported to the physician or nurse practitioner (NP)." When interviewed on 12/29/15, at approximately 8:50 a.m. the DON confirmed R6 was unable to understand or be understood, and staff communicated using gestures and facial expressions. The facility diagnostic report indicated R6 was admitted to the facility in 2014, with diagnoses including dementia without behavioral disturbance with a cognitive communication deficit. R6's annual MDS assessment dated 10/9/15, revealed the resident had severely impaired cognition with daily wandering that significantly intruded on the privacy of others, physical behavior towards others 1-3 days, other behavior not directed towards others 4-6 days but less than daily. The MDS also indicated R6 required	2 830		

REVISED

(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) COMPLETE DATE
2 830	Continued From page 34	2 830		

extensive assistance with bed mobility, transfer, locomotion on/off unit, dressing, toilet use, and personal hygiene. The MDS further indicated neither the resident nor family/significant other was able to complete the daily and activity preference portion of the assessment.

R6's care plan dated 10/12/15, indicated a risk for falls related to (r/t) history of falls, generalized weakness, gait/balance problems, bladder incontinence, hearing and vision impairments, impaired cognition, and difficulty communicating needs. Interventions included: anticipate and meet needs, encourage activities that promoted exercise, physical activity for strengthening and improved mobility, ambulate with staff in hallway three times daily, redirect when wheeling close to wall or objects, use distraction when restless. The care plan further identified a communication problem r/t hearing deficit and head injury. Interventions included: discuss with resident/family concerns or feelings regarding communication difficulty, family reported that they were unable to communicate with resident due to the progression of his dementia, observe effectiveness of communications strategies and assistive devices.

On 12/29/15, R6 was continuously observed from 1:16 to 4:17 p.m.:
- At 1:16 p.m. R6 was observed being ambulated by two staff with a third pushing the resident's wheelchair (w/c) behind him down the west "Cityside" hallway. The resident was cooperative while walking and although could not be understood, spoke and smiled to the staff, who in turn talked to the resident. After walking the length of the hall, the resident was assisted back to the dayroom in front of the television (TV). R6 then propelled himself throughout the dayroom in

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ________ B. WING ________	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 830	Continued From page 35	2 830		

his w/c.

-At 1:27 p.m. NA-A brought R6 a sensory item that was rounded in shape and consisted of multiple-colored hollow tubes held together with a -type cord enabling the object to be stretched and manipulated. R6 accepted the item, talking out loud constantly and NA- walked away. R6 held the item but did not appear interested, nor did he attempted to manipulate the object.

-At 1:34 p.m. a staff member transported R6 from the middle of the dayroom to a table with another resident. R6 continued to verbalize while the sensory object remained in his lap. No interaction with staff and R6 was observed. R6 remained at the table for a short time and then began to propel himself in w/c around the dayroom.

-At 1:44 p.m. R6 started to propel behind the nurses' station. LPN-C redirected the resident away from the area and then assisted him to his room.

-At 1:52 p.m. R6 propelled himself out of his room to the drinking fountain in the west hallway. R6 had a plastic mug and was attempting to obtain water from the fountain. A staff member approached R6 and assisted him with filling the mug with water then replaced the cover on the mug. R6 accepted the water mug then continued to mumble out loud and propel himself down the west hallway towards the administrative offices. Once R6 made it to the end of the hallway, staff intercepted the resident and returned him to his room.

-At 2:00 p.m., R6 was lying in bed on top of covers without shoes. A sensory item the

REVISED

2 830 | 2 830

Continued From page 36

resident was holding earlier was on the resident's legs. R6 eyes were wide open.

-At 2:07 p.m. R6 was sitting up on the edge of the bed with feet dangling, and the sensory item was on his lap. The resident was not touching or paying attention to the sensory object.

- At 2:30 p.m. R6 was seated on the edge of his bed. His left shoe was off his foot, as he held his other shoe and pulled out the laces.

-At 2:39 p.m., R6 continued to sit on the edge of bed in room attempting to pull the laces out of his left shoe. Coffee social and word games activity was being conducted in the dining room at that time. At 2:56 p.m. R6 continued to sit on edge of bed having successfully removed the laces from his shoe. At 3:10 p.m. NA-C entered R6's room and greet him. A trained medication aide (TMA)-A entered the room and asked if the resident was still "working on his shoe." NA-C asked if R6 was supposed to have the shoe. TMA-A responded that if she could get it laced and on the resident, then they could put him in his chair and not worry about it. On 12/29/15, at 3:57 p.m. R6 seated on side of bed examining the unlaced shoe. A wellness group was scheduled to begin at 4:00 p.m. On 12/29/15, at 4:17 p.m. R6 was still on the edge of the bed, attempting to re-lace his shoe. This activity had been continuous since 2:30 p.m. or nearly two hours.

R6 was not approached and/or involved in any significant staff to resident communication during the three hour continuous observation on 12/29/15. The resident was handed a sensory object though staff failed to model how object could be used or spend time with the resident. Staff provided minimal interaction with R6 and

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 37	2 830		

continually redirected him to his bedroom and eventually put into bed though the resident was wide awake.

R6 was observed on 12/30/15, during the following times:
- At 7:50 a.m. R6 was seated alone at a table in the corner of the dining room eating breakfast independently. The table was pushed flush to the wall on two sides. R6's back was to the other residents as he faced the wall.

- At 7:58 a.m. R6 was assisted in the w/c by staff to the Cityside dayroom and was situated at a table. Staff handed him a multicolored cylinder shaped sensory object that also made sound when manipulated. Staff then left the area without further interaction. R6 placed the object behind him on the seat of his w/c and proceeded to propel himself past the nurses' station towards the dining room to the medication cart where LPN-C was standing. Although R6 could not be understood, he vocalized loudly. LPN-C informed R6 he had already eaten and assisted the resident back to his room. LPN-C left the resident's room at 8:05 a.m. R6 was lying on the bare mattress and pillow without a pillowcase. The bedding was piled at the end of the bed. R6 was holding onto the grab bar, attempting to sit up in bed.

-At 8:25 a.m. R6 was seated at the edge of the bed and the w/c was positioned next to bed with the brakes locked. R6's tennis shoes were located on the seat of the w/c. At 8:36 a.m. R6 was wearing shoes, and was ambulating along the side of the room as he felt the wall. The surveyor alerted the administrator who was walking by to question whether R6 was capable of independent ambulation. The administrator

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 830	Continued From page 38 stated R6 did sometimes ambulate, and redirected R6 to his wheelchair. The administrator asked R6 whether he needed his oxygen (O2) as he was heavily breathing. The O2 was applied via a nasal cannula and the administrator left the room. - At 8:49 a.m. R6 removed the 02 tubing, propelled himself from the room via the w/c and entered another resident's room located across the hall. Upon entering the doorway, housekeeping (Hspkg)-A intervened and redirected R6 back to his own room. -At 10:04 a.m. a church activity was conducted in the activity room. R6 independently propelled himself down the west hallway but once he turned the corner, the administrator redirected and propelled him back down the direction of the hallway. R6 then entered the dayroom, propelling himself around the perimeter of the area, pausing to look out the window and watched the fish in the fish tank. R6 propelled himself toward the direction of the east hallway and remained seated here until 10:30 a.m. LPN-C then moved R6 from the east hallway to a table located in the dayroom. No verbal communication nor interaction was noted between staff and R6. -At 11:07 a.m. R6 was seated in w/c in dayroom by nurses station. A wellness activity in process and was identified on the plan of care as an planned intervention. At 11:27 a.m. R6 was seated in w/c in Cityside dayroom near nurses station when the activity director (AD) entered the dayroom, said "Hi" to R6, turned up the volume on the TV and walked away. At 11:48 a.m. R6 remained seated at the table in the corner of the dining room with his back away from the other residents.	2 830		

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 830	Continued From page 39	2 830		

-At 2:16 p.m. NA-B and NA-A attempted to assist R6 to ambulate, however, the resident did not stand when prompted for approximately 30 seconds. The transfer belt was removed and the staff left the resident.

-At 2:35 p.m. R6 was in the dining room where the men's group activity was held in the main area of the dining room. R6 was served a snack while located in the front area of the main dining room, partitioned off by a wall with two openings. R6 was offered his snack at the table where he routinely had been served meals, alone and away from the other residents who were served their snacks in the main dining area. At 2:41 p.m. when R6 finished his snack, propelled himself around the front area of the dining room near his designated table. No staff interacted with R6 until he was assisted out of the dining room towards the direction of his room at 2:44 p.m. When interviewed on 12/30/15, at 12:41 p.m. the AD cited a communication barrier.

When interviewed on 12/20/15, at 3:36 p.m. TMA-A indicated they were unable to communicate with the resident and had not attempted any alternative method, and said it was unfair to R6. TMA-A said R6's family visited approximately monthly.

When interviewed on 12/31/15, at 8:50 a.m. the licensed social worker (LSW) and DON stated they were unsure whether R6 would have been able to talk to his family on the telephone. Although they had never attempted to assist him to contact his family, they said it would be worth attempting.

When interviewed on 12/31/15, at 1:25 p.m. the

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 830	Continued From page 40 DON confirmed the R6 should not have been returned to his room or put into bed when he wandered. The DON stated, "That's sad" when informed the resident had been put into bed with a bare mattress, linen pushed to the end of the bed, and no pillowcase on the pillow. The DON agreed staffs' interventions and/or lack of appropriate interventions was concerning. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are monitoring and providing cares as necessary to meet the needs of residents. The director of nursing or designee could monitor for compliance through audits of medical records. The results of these audits could then be presented at the quarterly QA&A meetings. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 965	Completion Date: 2-8-16	2/8/16

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 965	Continued From page 41	2 965		

Continued From page 41

review, the facility failed to ensure interventions were implemented to prevent significant weight loss for 1 of 3 residents (R28) reviewed for nutritional status.

Findings include:

R28's physician order sheet dated 7/1/15, revealed diagnoses including stroke, chronic kidney disease and dementia.

The quarterly Minimum Data Set (MDS), dated 12/11/15 revealed R28 had a weight loss of 5% in the past month or 10% in the past 6 months. The residents current weight at 150#. No chewing or eating problems. The MDS further identified R28 had experienced a weight loss of 20# pounds (lbs) from the previous MDS dated 9/16/15, of a significant change.

REVISED

Review of the most current care plan identified R28 as having potential nutritional problems due to dementia and decreased cognition. Interventions listed include: staff assist to set up residents meals, monitor the residents intake and report any changes to the physician, monitor the residents weights and report to the physician any significant weight loss and allow the resident time to eat in a calm setting.

Review of R28's log of weights revealed a 20 lb loss from 170 to 150 lbs. between 9/15 and 12/15 (3 month period).

Review of R28 nutritional assessment dated 10/14/15 indicates the residents weight was at 170#. The resident eats an average 75-100% of his meals and is on a regular diet with no chewing or swallowing problems.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 965	Continued From page 42	2 965		

Review of R28's mini nutritional assessment dated 12/14/15, with a significant change indicates the residents food intakes are stable and has not declined. The resident is showing a weight loss of 20# in the past 3 months and is at risk for malnutrition. No other information was documented related to causal factors nor interventions related to the weight loss.

Review of R28's dietary intakes for the previous 3 months revealed intakes ranging from 0-100% at meals. Average daily intake of food is 25-50%. The residents food intake log revealed the resident had an increased decline in eating for the months of 11/15 and 12/15.

R28's most current dietary progress note, completed by the dietician on 12/15/15, indicated the resident's significant weight loss may be related to the residents increased dementia and requiring more assistance with setting up his meals. No recommendations were provided.

During interview with the dietary director (DD) on 12/29/15 at 2:00 p.m., indicated she was unsure of who was responsible for monitoring R28's weights, but confirmed she had completed the most current MDS assessment which triggered/identified R28's significant weight loss. The DD stated R28's weight loss had been discussed with the registered dietician (RD) on 12/15/15, but the RD did not provide any recommendations.

During observations of R28 eating breakfast on 12/30/15, at 8:00 a.m. staff were feeding the resident his meal. The resident consumed 90% of his meal but did not participate in the process. The resident received a regular mechanical soft diet with no chewing or swallowing problems.

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 965	Continued From page 43	2 965		

During interview with the facility RD on 12/30/15, at 8:00 a.m. she confirmed she was aware of R28's significant weight loss and stated the nursing staff indicated R28's weight loss was probably due to his dementia and he required more assistance with eating. The RD further included she did not recommend any type of intervention nor recommendation for R28's weight loss due to the residents body mass index (BMI) being within normal ranges. The RD further stated she was not concerned about a residents weight loss if they fall within their BMI, but may follow up the following month. When further questioned, the RD did confirm R28's significant weight loss should have been addressed by the staff for causal factors and follow up interventions.

REVISED

SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise current policies and procedures related to weight loss and residents nutritionally at risk. The director of nursing or designee could educate responsible staff on the policy changes as well as audit to ensure all current recommendations are being carried out within the dietary department. The director of nursing or designee could conduct audits for compliance and review with the quality assurance committee.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General	21435		2/8/16

Subpart 1. General requirements. A nursing home must provide an organized activity and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21435	Continued From page 44	21435		

recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review the facility failed to provide activities for 2 of 3 (R6, R23) residents reviewed for activities.

Completion Date: 2-8-1[illegible]

REVISED

Findings include:

R6
R6 was admitted to the facility on 9/5/14, with diagnoses including dementia without behavioral disturbance, cognitive communication deficit, chronic obstructive pulmonary disease (COPD), muscle weakness and difficulty walking per the facility diagnosis report.

R6's annual Minimum Data Set (MDS) assessment dated 10/9/15, indicated severely impaired cognition with daily wandering that significantly intruded on the privacy of others, physical behavior towards others 1-3 days, other behavior not directed towards others 4-6 days but less than daily. The MDS further indicated neither the resident nor family/significant other could complete the daily and activity preference portion of the assessment. The staff assessment of daily and activity preferences indicated the

21435 — 21435

Continued From page 45

resident preferred receiving a tub bath, snacks between meals, staying up past 8:00 p.m., family or significant other involvement in care discussions, listening to music and spending time outdoors.

R6's annual Recreation/Wellness Assessment dated 10/4/15, indicated information was given by R6's son from the previous assessment. The assessment identified current interests as: group participation in intergeneration programs with specific interest with school kids singing, golf cart rides, visiting in person/on phone with family, walks/bicycling. The assessment also included past preferences of watching wrestling on TV and Charlie Chan movies.

R6's care plan for activities dated 10/12/15, indicated the resident was primarily independent but occasionally needed some guidance with structuring leisure activities that promote wellness. Interventions identified on the care plan:
(1.) CD player in room; please play music per resident's desire.
(2.) Recreation/Wellness preferences include: exercise, listening to music, watching TV (enjoys wrestling and war movies) food related activities, sensory and 1:1 time.
(3.) EMOTIONAL: Offer ipod or CD player for individual music enjoyment.
(4.) PHYSICAL: Encourage participation in Well-Fit program to include group exercise and/or individual cardio. The activity goal indicated R6 would work on puzzles in day room by the review period.

When interviewed on 12/29/15, at approximately 8:50 a.m. the director of nursing (DON) confirmed R6 did not speak nor understand English. DON

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21435		21435		

Continued From page 46

further indicated staff communicated with the resident through gestures and facial expressions.

Continuous observations of R6 on 12/29/15, from 1:16 p.m. until 4:17 p.m., revealed the following:

- At 1:16 p.m. R6 was ambulated with the assistance of two staff, a 3rd staff pushed the residents wheelchair (w/c) behind him down the west Cityside hallway. Staff were responding in English to his vocalizations. After R6 ambulated the length of the hall staff seated him back in the w/c, removed the transfer belt and transferred him to the dayroom area located by the nurses' station. Staff moved him in front to the television and then R6 propelled himself in the w/c throughout the dayroom.

- At 1:27 a.m. nursing assistant (NA)-A brought R6 a round shaped sensory item which consisted of multiple-colored hollow tubes held together with a bungy type cord. This enabled the object to be stretched and manipulated. R6 accepted the item, talking out loud constantly. Although R6 held the item, he did not appear interested nor did he attempt to manipulate or pull the sensory item. NA-A left the area after the item was delivered to R6. R6 remained in the commons area until 1:44 p.m., when licensed practical nurse (LPN)-C assisted him back to his room.

-At 1:52 p.m. R6 left his room via the w/c to obtain water in his plastic mug from the drinking fountain located in the west hallway. Staff assisted him with the task, replaced the lid and left the area. With a water-filled mug, R6 continued to vocalize as he propelled the w/c down the west hallway. It was noted that once R6 arrived at the end of the hallway, staff intercepted and returned him back to his room.

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21435	Continued From page 47 -At 2:00 p.m., R6 was observed lying in bed on top of covers with shoes on. The sensory item given to him earlier was placed on his legs. R6 was not touching nor handling the item even though he appeared to be wide awake. At this time, a popcorn and movie activity was occurring in the activity room, however R6 was not assisted to attend. At 2:14 p.m. staff entered the room to distribute fresh water, greeted R6 and left immediately. -At 2:30 p.m., R6 was seated on the edge of his bed in room with the left shoe off and was holding a shoe on his lap, removing the laces. The sensory object was no longer visualized. No music was playing in the room. From 2:39 until 4:17 p.m., R6 was observed attempting to remove and replace the lace from his left shoe. Although coffee social, wellness group and word games activities were held in the dining room at this time, R6 was not assisted or offered to attend. At 3:10 p.m. NA-C entered the room and greeted R6. Trained medication aide (TMA)-A also entered the room and asked whether R6 was still "working on his shoe". NA-C asked TMA-A whether R6 was supposed to have the shoe. TMA-A responded that if NA-C could get it laced and on R6, they could transfer him into his chair and not worry about it, however NA-C did not assist R6. Observations of R6 on 12/30/15 revealed the following: - At 7:50 a.m. R6 was observed seated alone at a table in the corner of the dining room eating breakfast independently. The table was pushed flush to the wall on 2 sides. R6 had his back to the other resident's in the dining room, facing only	21435		

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21435	Continued From page 48	21435		

the wall. At 7:58 a.m. R6 was assisted in the w/c by staff to the Cityside dayroom and placed at a table. Staff handed R6 a multicolored cylinder shaped sensory object that also made sound when manipulated. Staff then left the area without further interaction. R6 placed the object behind him on the seat of his w/c and proceeded to propel self past the nurses' station towards the dining room to the medication cart where LPN-C was standing. LPN-C responded to R6 that he had already eaten and assisted in propelling him back to his room. LPN-C left the resident's room at 8:05 a.m. R6 was lying on his bed with the bare mattress exposed and bedding in a clump at the end of bed; no pillowcase was on R6's pillow. R6 was observed holding on to the grab bar attempting to sit up in bed.

-At 8:25 a.m. R6 was seated at the edge of the bed and the w/c was positioned next to bed with the brakes locked. R6's tennis shoes were located on the seat of the w/c. At 8:36 a.m. R6 was observed ambulating in his room. R6 had shoes on and was feeling the wall as he walked along side the wall. The surveyor alerted the administrator who was walking by to question whether R6 was capable of independent ambulation. The administrator stated R6 does ambulate sometimes as observed and redirected R6 to his w/c. The administrator asked R6 whether he needed his oxygen (02) as he appeared to be breathing heavy. The 02 was applied via a nasal cannula and the administrator left the room. At 8:49 a.m. R6 removed the 02 tubing, propelled himself from the room via the w/c and entered another resident's room located across the hall.

-At 10:04 a.m. a church activity was conducted in the activity room. R6 independently propelled

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21435	Continued From page 49	21435		

himself down the west hallway but once R6 turned the corned, the administrator redirected and propelled him back down the direction of the hallway. R6 then entered the dayroom, propelling self around the perimeter of the area, pausing to look out the window and then watched the activity in the fish tank. R6 propelled himself toward the direction of the east hallway and remained seated near this area until 10:30 a.m. LPN-C then moved R6 from the east hallway to a table located in the dayroom. No verbal communication nor interaction was noted between staff and R6. R6 was not offered/assisted to the church activity at anytime throughout the noted observations nor did staff interact with the resident.

-At 11:07 a.m. R6 was observed seated in w/c in dayroom by nurses station; Wellness activity was currently in process and was identified on the plan of care as an planned intervention. At 11:27 a.m. R6 was seated in w/c in Cityside dayroom near nurses station when the activity director (AD) entered the dayroom, said "Hi" to R6, turned up the volume on the TV and walked away. At 11:48 a.m. R6 remained seated at the table in the corner of the dining room with his back to other resident's as noted during the breakfast meal.

-At 2:35 p.m. R6 was observed in the dining room where the men's group activity was held in the main area of the dining room. No activity staff were noted to interact with R6 until they assisted out of the dining room towards the direction of his room at 2:44 p.m.

When interviewed on 12/30/15, at 12:41 p.m. the AD stated R6 is very "antsy" r/t group activities and is scheduled for in-room programming. AD further indicated that 2 in-room activity programs were scheduled for 20 minutes/day. AD also

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
21435	Continued From page 50 stated staff will also offer coffee social time as well as the men's group activity as well as three 1:1 visits weekly. AD confirmed there was a language barrier related to attending activities and that an interpreter from the high school came to the facility on 12/4/15 but had not returned since. AD stated trying to get hold of the interpreter but calls had not been returned. AD stated a few weeks ago a representative from another facility came to assess the resident for possible placement. The representative was able to converse with R6 in his native language and discovered he enjoyed weaving baskets. When requested documentation related to activities provided for R6, the following was noted: (11/2/15 thru [illegible]/15) - R6 received only two 1:1's with staff (11/4 & 11/7). The week of 11/16-11/22/15 R6 received 1:1 activity. Although the AD indicated she had provided 1:1 in-room programming with R6, she was unable to provide documentation to demonstrate this had been implemented nor could she recall when this had occurred. AD stated she offered an Ipod with headphones for R6 to listen to music in his own language. The AD then provided documentation indicating the Ipod was offered 5 times in November and 4 times in December 2015. When questioned about the preferred activities (wrestling and war movies) documented on R6's care plan, she indicated being unaware of these preferences. When the current activity sheets were reviewed to substantiate the activities each resident had attended, there was nothing highlighted and/or documented indicating that R6 had been involved in activities during the days of observations. When further interviewed on 12/31/15, at 10:21 a.m. the AD was unable to provide documentation	21435		

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21435	Continued From page 51	21435		

of activities offered in 11/15 and provided 5 days of activity sheets for 10/15, and provided only ten days of documentation for 12/15. The sheets indicated R6 attended exercise on 12/21/15, and the AD stated he did really well with it. The activity sheets failed to document whether R6 had participated, wandered away and/or refused the activity; the AD confirmed the activity documentation was incomplete.

R23

R23 was admitted on 1/6/15 with diagnoses including: dementia, paranoid personality, mood disorder, and chronic obstructive pulmonary disease (COPD) per the facility diagnosis report. The report further identified R23 was admitted to hospice services on [illegible]/15/15 due to senile degeneration of the brain.

R23's quarterly Minimum Data Set (MDS) assessment dated 11/6/15, indicated R23 severely impaired cognition, total dependence with locomotion on/off unit, and extensive assistance with bed mobility, transfer, eating, toilet use, and personal hygiene.

R23's significant change MDS assessment dated 5/6/15, indicated activity preferences as: very important to have books, magazines, newspapers to read, very important to do favorite activities, very important to go outside and get fresh air when weather is good, and very important to participate in religious services or practices.

R23's care plan last revised 11/9/15, indicated the resident was dependent on staff for structuring and providing activities that promote wellness stimulation due to cognitive deficits. Interventions included: (1) "1 to 1 bedside/in-room visits and

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
21435	Continued From page 52 activities if [resident name] is unable to attend out of room events. (2) COGNITIVE: Encourage participation in small groups and/or 1:1 interactions (3) EMOTIONAL: Offer ipod or CD player for individual music enjoyment. (4) ENVIRONMENTAL: Observe [resident name] body language related to over stimulation [Resident name] Recreation/Wellness individual preferences include Bingo, walks, magazines, word search, TV and listening and playing music." R23 was observed continuously on 12/29/15, from 1:14 p.m. until 3:56 p.m. while lying in bed. A popcorn and move activity was held at 1:30 p.m. in the activity room and the coffee social activity held at 2:30 p.m. in the dining room. Staff did not offer R23 the opportunity to attend either activity. R23 was again observed continuously on 12/30/15, from 10:03 a.m. until 10:23 a.m. At 10:03 a.m. R23 was seated in a geri chair in the Cityside dayroom at a table while a church service was currently being held in the activity room. At 10:21 a.m. R23 remained in the geri-chair with eyes closed. The AD approached another resident seated in w/c located near the Cityside nurses station and asked whether she wanted to attend church. R23 opened her eyes when the AD and the resident left for church but looked away and closed her eyes when they left the area. NA-A then approached R23 at 10:23 a.m. to ask whether she wanted to lay down. R23 nodded "yes". NA-A did not give her the opportunity to attend the church activity before transporting her to her room. At 11:08 a.m. R23 was observed lying in bed with	21435		

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21435	Continued From page 53	21435		

eyes closed while a Wellness activity was in process. She had not been given the opportunity to attend this activity.

At 3:12 p.m. R23 was again lying in bed with eyes closed. A music activity was being performed in the Cityside dayroom with a resident's family member piano playing. Staff were not observed to offer attendance to the activity to R23.

When interviewed on 12/30/15, at 11:55 a.m. NA-B and NA-A confirmed they had assisted R23 with her morning cares, stating that when offered activities, she often refuses as prefers to lie down. Both NA's confirmed they had not offered R23 attendance at the morning church activity as R23 had been tearful that morning when receiving care and they felt the resident would rather lie down. NA-B further stated the resident liked to color when first admitted and will attend church though at times will become disruptive during the service.

When interviewed on 12/30/15, at 1:40 p.m. the AD stated R23's activities included hair care, a daily Sunshine group (sensory group) which is implemented twice daily Monday-Friday and once on Saturdays). AD stated the resident usually does fine while attending church service but sometimes needed to be removed from the service as would get agitated. AD confirmed she would still expect R23 be offered the opportunity to participate in attending church. AD attempted to located documentation of activities attended and 1:1's provided for R23. The 1:1 activity sheets indicated R23 was to have 1:1's three times/weekly. AD provided 1:1 documentation from 11/2/15 - 12/5/15 (minus the week of 11/16/15 - 11/22/15); R23 was provided a 1:1 on 7 occasions during this period (11/5/15, 11/7/15,

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21435	Continued From page 54	21435		

11/12/15, 11/13/15, 11/27/15, 12/4/15, 12/7/15). AD confirmed the 1:1 charting was inadequate and did not identify the activity, time and/or response. Staff would not be able to evaluate effectiveness of planned interventions.

When interviewed on 12/31/15, at 10:21 a.m. the AD provided 10 days of December 2015 activity sheets for R23. The sheets indicated R23 was offered activities on 5 of the 10 days. AD was unable to provide documentation of activities offered in November 2015 and provided 5 days of activity sheets for October 2015. The activity sheets did not include evidence if the resident had participated or refused the activity, AD confirmed the charting of activities was incomplete.

REVISED

SUGGESTED METHOD OF CORRECTION: The activity director could train all staff to ensure each resident's assessed activity preferences are honored, and then audit to ensure this is occurring. Results of these audits could then be reviewed at the quality assurance meetings.

TIME PERIOD FOR CORRECTION: Twenty One (21) days.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin	21565		2/8/16

Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.

This MN Requirement is not met as evidenced

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
21565	Continued From page 55	21565		

Continued From page 55

by:
Based on observation, interview, and document review the facility failed to ensure the safe practice of self-administration for 1 of 2 residents (R6) who were observed self- administering a nebulizer treatment.

Findings include:

R6's physician orders dated 12/8/15, included Ipratropium-Albuterol solution 0.5-2.5 (3) milligrams/3 milliliters, 1 vial inhale orally three times a day for shortness of breath, every 6 hours while awake.

R6's annual Minimum Data Set (MDS) dated 10/9/15, indicated R6 had severe cognitive impairment.

Review of R6's care plan dated 10/12/15 included a risk for alteration in respiratory status related to (r/t) diagnoses of emphysema/COPD (chronic obstructive pulmonary disease) with recurrent acute episode. History of (h/o) pneumonia, and h/o bronchospasms (sudden constriction of the muscles in the walls of the bronchioles causing difficulty breathing). The care plan further identified a behavior problem r/t dementia which included routinely refusing neb (nebulizer) treatments.

Further review of the medical record did not include evidence of an assessment related to R6's ability to self-administer medications.

On 12/29/15, at 2:39 p.m. two surveyors observed R6 sitting on the edge of his bed wearing a nebulizer mask with machine running and medication noted in the nebulizer solution receptacle. R6 was alone in the room with no

Provider's Plan of Correction: Completion Date: 2-8-16

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21565	Continued From page 56	21565		

staff present within visualization of the resident.

On 12/29/15, at approximately 2:50 p.m. licensed practical nurse (LPN)-D was observed in R6's room. R6 was sitting on the edge of bed though no longer had the nebulizer mask on nor was the machine running.

When interviewed on 12/31/15, at 9:09 a.m. the director of nursing (DON) confirmed R6 did not have an assessment to self administer medications; the medication nurse was expected to remain with the resident throughout a nebulizer treatment. DON further confirmed C6 had a history of being non-compliant with administration of nebulizer treatments.

The facility policy/procedure titled, Nebulizers included: "10. Monitor the resident throughout the treatment."

SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee ensure the appropriate assessments are conducted to ensure the safe administration of medications. The DON could ensure the staff were educated on the importance of the assessment process. The DON or designee could randomly audit resident records to ensure adequate monitoring and documentation was in place. The DON could could random audits to ensure medication is not left with residents unless deemed safe by the interdisciplinary team. Results of these audits could then be presented at the quarterly QA&A meetings.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ____ B. WING ____	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21695	Continued From page 57	21695		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure 1 of [illegible] rooms (Room 109, R6) reviewed with floor or wall damage had bathroom sheet rock that was maintained in good repair. Findings include: During observation of bathroom in room 109 (R6) on 12/31/15, at 8:30 a.m. it was noted to have a hole approximately 15 inches by 4 inches in the sheetrock at the base of the bathroom wall which is adjacent to the tub room. During observation and interview on 12/31/2015, at 8:35 a.m. the maintenance director confirmed the damaged wall in the bathroom of room 109. He stated, "tub has been leaking and this has damaged the resident's wall". He indicated the tub room was adjacent to R6's bathroom. The maintenance director further confirmed a quarter size hole in the wall below the toilet paper dispenser and agreed the areas in the bathroom did not create a homelike environment. The maintenance director could not provide a policy/procedure but indicated staff would fill out a request on the clipboard when there was a problem to be fixed.	21695	Completion Date: 2-8-16	2/8/16

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21695	Continued From page 58 SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure resident rooms and bathrooms are in good repair. The administrator or designee could educate all appropriate staff on the policies and procedures for reporting of damage or need for repair. The administrator or designee could develop monitoring systems to ensure ongoing compliance. Results of these monitoring/audits could then be reviewed at the quarterly QA&A meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21975	MN St. Statute 144A.10 Subd. 3 Inspection; Commissioner of Health; Fines Subd. 3. Reports; posting. A copy of each correction order and notice of noncompliance, and copies of any documentation supplied to the commissioner of health or the commissioner of human services under section 144A.03 or 144A.05 shall be kept on file at the nursing home and shall be made available for viewing by any person upon request. Except as otherwise provided by this subdivision, a copy of each correction order and notice of noncompliance received by the nursing home after its most recent inspection or re-inspection shall be posted in a conspicuous and readily accessible place in the nursing home. All correction orders and notices of noncompliance issued to a nursing home owned and operated by the state or political subdivision of the state shall be circulated and posted at the first public meeting of the governing body after the order or notice is issued.	21975		2/8/16

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21975	Continued From page 59	21975		

Confidential information protected by section 13.05 or 13.46, shall not be made available or posted as provided in this subdivision unless it may be made available or posted in a manner authorized by chapter 13.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review the facility failed to ensure the most current survey results were posted in an area readily accessible to residents, families and visitors. This had the potential to affect all [illegible]0 residents currently residing in the facility.

Completion Date: 2-8-16

REVISED

Findings include:

During the initial tour of the facility with the director of nursing (DON) on 12/28/15, at 12:00 p.m., observations revealed the current federal and state survey results were not available to residents, families or visitors. The DON indicated the results are usually posted on the bulletin board near the north and south nurses stations, but confirmed they were not. After 15 minutes of looking for the survey results, the DON found them to be in a 3 ring binder placed behind the south nurses station in the residents chart stand. The binder which included the survey results was not visible nor easily accessible to the residents, families or visitors. The DON confirmed this.

SUGGESTED METHOD OF CORRECTION:
The administrator or designee could re-educate staff to assure the facility survey results are accessible to all residents. The administrator or designee could monitor for continued compliance.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ________ B. WING ________	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21975	Continued From page 60 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21975		

REVISED

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ZNOX
Facility ID: 00731

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245378**

2. STATE VENDOR OR MEDICAID NO. (L2) **425340000**

3. NAME AND ADDRESS OF FACILITY
(L3) **VALLEY VIEW MANOR HCC**
(L4) **200 EAST NINTH AVENUE**
(L5) **LAMBERTON, MN** (L6) **56152**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **2/17/2016** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NE II 02/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/25/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
______

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00803
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245378

February 25, 2016

Ms. Dawn Giese, Administrator
Valley View Manor HCC
200 East Ninth Avenue
Lamberton, MN 56152

Dear Ms. Giese:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 8, 2016 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
February 24, 2016

Ms. Dawn Giese, Administrator
Valley View Manor HCC
200 East Ninth Avenue
Lamberton, MN 56152

RE: Project Number S5378029

Dear Ms. Giese:

On January 20, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 31, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 17, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 16, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 31, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 8, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 31, 2015, effective February 8, 2016 and therefore remedies outlined in our letter to you dated January 20, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245378		2/17/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 02/08/2016	ID Prefix F0167 Reg. # 483.10(g)(1) LSC	Correction Completed 02/08/2016	ID Prefix F0176 Reg. # 483.10(n) LSC	Correction Completed 02/08/2016
ID Prefix F0248 Reg. # 483.15(f)(1) LSC	Correction Completed 02/08/2016	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 02/08/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 02/08/2016
ID Prefix F0325 Reg. # 483.25(i) LSC	Correction Completed 02/08/2016	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 02/08/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 2/24/2016	SIGNATURE OF SURVEYOR 32603	DATE 2/17/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/31/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245378	A. Building 01 - MAIN BUILDING 01 B. Wing	2/16/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 01/04/2016	ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 01/06/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 2/24/2016	SIGNATURE OF SURVEYOR 35482	DATE 2/16/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/29/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered

February 24, 2016

Ms. Dawn Giese, Administrator
Valley View Manor HCC
200 East Ninth Avenue
Lamberton, MN 56152

Re: Reinspection Results - Project Number S5378029

Dear Ms. Giese:

On February 17, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 31, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
00731		2/17/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)		DATE (Y5)	ITEM (Y4)		DATE (Y5)	ITEM (Y4)		DATE (Y5)
ID Prefix	20265	Correction	ID Prefix	20302	Correction	ID Prefix	20565	Correction
Reg. #	MN Rule 4658.0085	Completed	Reg. #	MN State Statute 144.6503	Completed	Reg. #	MN Rule 4658.0405 Subp. 3	Completed
LSC		02/08/2016	LSC		02/08/2016	LSC		02/08/2016
ID Prefix	20830	Correction	ID Prefix	20965	Correction	ID Prefix	21435	Correction
Reg. #	MN Rule 4658.0520 Subp. 1	Completed	Reg. #	MN Rule 4658.0600 Subp. 2	Completed	Reg. #	MN Rule 4658.0900 Subp. 1	Completed
LSC		02/08/2016	LSC		02/08/2016	LSC		02/08/2016
ID Prefix	21565	Correction	ID Prefix	21695	Correction	ID Prefix	21975	Correction
Reg. #	MN Rule 4658.1325 Subp. 4	Completed	Reg. #	MN Rule 4658.1415 Subp. 4	Completed	Reg. #	MN St. Statute 144A.10 Subd. 3	Completed
LSC		02/08/2016	LSC		02/08/2016	LSC		02/08/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 2/24/2016	SIGNATURE OF SURVEYOR 32603	DATE 2/17/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/31/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: ZNOX12

DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ZNOX
Facility ID: 00731

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245378**

2. STATE VENDOR OR MEDICAID NO. (L2) **425340000**

3. NAME AND ADDRESS OF FACILITY
(L3) **VALLEY VIEW MANOR HCC**
(L4) **200 EAST NINTH AVENUE**
(L5) **LAMBERTON, MN** (L6) **56152**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/31/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 02/03/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/24/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00803
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
January 20, 2016

Ms. Dawn Giese, Administrator
Valley View Manor Hcc
200 East Ninth Avenue
Lamberton, MN 56152

RE: Project Number S5378029

Dear Ms. Giese:

On December 31, 2015, a standard survey was completed at your facility by the Minnesota Departments 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**
>
> **Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.**

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 9, 2016 the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 9, 2016 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by March 31, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 1, 2016 (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.

INFORMAL DISPUTE RESOLUTION

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:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 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 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 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		2/8/16

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

Electronically Signed — 01/29/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ________ B. WING ________	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician in a timely manner for 2 of 4 residents (R46, R21) reviewed for hospitalization who experienced significant changes in condition requiring medical treatment. This resulted in actual harm for R46, who experienced prolonged discomfort, dehydration and vomiting, related to delayed physician notification and subsequent transfer to an inpatient facility for a small bowel obstruction. Findings include: R46's discharge orders to the nursing home dated 9/17/15, identified a discharge condition of improving with orders for physical and occupational therapy. R46's physician's progress notes, dated 9/18/15 indicated diagnoses of spinal stenosis of the lumbar region, sepsis, and urinary tract infection. The physician's progress note also identified a history of diverticulitis of the colon. R46's admission Minimum Data Set (MDS), dated 9/24/15 identified a Brief Interview for Mental	F 157	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Resident #21 s physician has been updated on a regular basis on the changes in her condition and overall status. Resident #46 is deceased. 2. All resident s were reviewed for any change in condition and need to notify the physician per phone call. All resident orders for insulin were reviewed and corrected where orders to call the physician for high glucose readings. Our standing orders were updated per recommendation of our medical director to notify the physician if two Blood Glucose results are <70 or >400 in a 24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 157	Continued From page 2 Status score of 13/15 (cognitively intact). No care area assessments were completed with the MDS. R46's care plan, dated 9/30/15 identified no cognitive impairments and that R46 desired to return to the community. R46's September 2015 medication sheets revealed R46 had received Maalox (an antacid) 30 cubic centimeters (cc)'s on 9/25/15 a total of four times on that date, as well as one dose at 2:00 a.m. on 9/26/15. Notations documented by licensed practical nurse (LPN)-A, on the back of the medication administration record for a dose administered on 9/25/15, at 2:00 a.m. indicated the medication had been given for stomach upset since supper. No follow up assessment for effectiveness was completed. A subsequent entry dated 9/26/15, at 2:00 am. indicated R46 had received another dose of Maalox for an upset stomach and emesis; the follow up result was listed as had another emesis at 4 a.m. None of the other doses administered had follow up results documented. A nursing progress note written by LPN-F on 9/25/15 at 8:30 a.m., indicated R46 had hiccups and complaints of not feeling well. The notes indicated R46 had been given Maalox 30 cc's along with Thorazine and had begun retching after his morning medications. In addition, R46 had experienced a large projectile emesis all over the bed and himself, and had refused to eat anything for breakfast, stating he had consumed orange juice that had all come up. A nursing progress note documented by LPN-F on 9/25/15, at 1:39 p.m. indicated R46 had a large emesis, and that the resident had stated he	F 157	hour period. 3. Education to licensed staff will be completed by 2-3-16 on ensuring that physicians are notified in a timely manner concerning any resident change in condition and that physician orders are obtained for elevated glucose levels, including orders to call the physician when there is two blood Glucose results <70 or >400 in a 24 hour period. 4. When residents present with a change of condition nurses will call the physician immediately (within a timely manner) and notify the Director of Nursing instead of using fax. Physician orders are obtained for elevated glucose levels, including orders to call the physician when there is two blood glucose results <70 or >400 in a 24 hour period. 5. The DNS or designee will complete 2 audits weekly for 4 weeks and weekly for 2 months to ensure that the facilities guide line is being followed correctly. 6. The data collected will be reviewed/discussed at the quarterly QA&A meeting. At this time the QA&A committee will make the decision/recommendation regarding any follow-up studies. The DNS will be responsible for this POC. Completion Date: 2-8-16 Valley View Manor Plans to IDR F157.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 157	Continued From page 3	F 157		

was not feeling well. The notes indicated his hiccups had subsided for a while but had then started again. Documentation indicated R46 had received Maalox and Thorazine (an antipsychotic medication used for antiemetic properties) with another small emesis afterward. The emesis was documented as having had food particles present and was described as having a colicky odor. R46's temperature was documented as having been elevated at 99.0 degrees Fahrenheit (F).

A nursing progress note dated 9/25/15, at 6:00 p.m. per LPN-F indicated R46 had stayed in bed most of the evening. The note indicated R46's hiccups were better over the early evening hours but that R46 had been stated his tummy still didn't feel right and that whenever he moved he began to gag. R46 had eaten Jell-O for supper and had sips of water. Additionally, the documentation indicated a fax (facsimile) had been sent to medical doctor (MD)-A with an update on R46's condition including that R46 had an elevated temperature at 99.5 degrees F and complained of feeling chilly.

A nursing progress note dated 9/25/15, at 11:05 p.m. per LPN-F indicated R46 had not been feeling well, and had been having brown colored emesis twice on the afternoon shift which did not appear to have a feces odor. Maalox 30 cc's had been given to help with hiccups and R46's vitamins had been held due to emesis.

A nursing progress note by LPN-A, dated 9/26/15, at 1:56 a.m. indicated R46's abdomen was distended, his bowel sounds were difficult to hear and he had been having emesis which looked like BM. R46's temp was noted to be slightly elevated at 99.1 degrees F.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 157	Continued From page 4	F 157		

Continued From page 4

A nursing progress note written by LPN-A on 9/26/15, at 4:48 a.m. indicated R46 had 100 cc's of emesis, like soft formed/loose BM (bowel movement) with no odor. The note further indicated R46 was cool and clammy, with a slightly elevated temperature at 99.1 degrees F. R46 had a wastebasket beside him, and continued to wretch.

A nursing progress note entered by LPN-B, dated 9/26/15, at 9:57 a.m. indicated R46 had two further emesis of greenish liquid thick with pieces of BM looking in it. In addition, the note indicated an acute care hospital had been called and an order was received to transfer R46 to their emergency room (ER) via ambulance. The note indicated R46's daughter was updated and had agreed to meet him at the hospital. R46 left the facility at 8:45 a.m.

A faxed physician's order dated 9/26/15 was present in R46's record and verified the physician order to transfer per ambulance to the acute care hospital.

An additional nursing progress note dated 9/26/15, at 2:06 p.m. indicated R46 had been admitted to the acute care hospital with a diagnoses of bowel obstruction, and would need surgery.

A faxed physician's order sent on 9/25/15, at 6:05 p.m. from the facility to R46's primary physician identified that R46 had emesis since 8:30 a.m., experienced several rounds of hiccups throughout the day and had been unable to eat or drink. R46 complained of feeling weak. The fax had not been signed off until on 9/28/15, three

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 157		F 157		

Continued From page 5

days later, when the nurse practitioner (NP)-A responded with a statement including, "Noting telephone order to transfer to ER on 9/26/15. Please do NOT fax in regard to situations that need attn [attention] that day. This will be sent to [physician] - today 9/28/15. Please review the faxing for response procedure. Thx [Thanks]."

The ER progress note dated 9/26/15, at 10:36 a.m. was reviewed. The ER note indicated R46 had appeared distressed when examined, had been uncomfortable, and had dry oral mucous with dried brown material on the tongue and lips. The ER note further indicated R46's abdomen was firm and diffusely distended, mildly tender with no appreciable bowel sounds. In addition, 1800 milliliters (ml) of brown liquid had been drained from R46's stomach after the insertion of a nasogastric tube. R46 had received 2000 ml of normal saline intravenous for hydration. The ER physician's note indicated R46 had appeared quite dehydrated and verified the admitting diagnoses of small bowel obstruction and severe dehydration.

The ER registered nurse's assessment dated 9/26/15, at 11:17 a.m. indicated: R46 had stated he'd been vomiting for the last two days and his emesis was now brown like stool. R46 had vomited three times in the ambulance enroute to the ER and the vomit was described as dark brown liquid running out of his mouth. R46's abdomen was very firm, with no bowel sounds and the abdomen was distended. R46 complained of abdominal pain but was unable to rate the pain. R46 had his stomach drained via a nasogastric tube for ten minutes with 1400 mL of fluid output after which R46 stated he felt much better. R46 was alert and "states we should do

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 157	Continued From page 6	F 157		

what ever we have to do. Is comfortable now."

The hospital discharge summary dated 10/5/15, indicated R46 had undergone abdominal surgery to correct the small bowel obstruction, and had developed subsequent cardiac and anticoagulation issues as well as post-operative ileus (disruption in normal bowel motility) after the surgery. The ileus resolved with the replacement of a nasogastric tube; however, comfort cares were initiated and R46 passed away on 10/5/15.

During interview on 12/29/15, at 3:07 p.m. the director of nursing (DON) verified she would have expected staff to contact the on-call doctor immediately with the urgent clinical issues, especially when the resident was vomiting BM-type material and not feeling better.

During interview on 12/29/15, at 3:32 p.m. the nursing home's health information coordinator/nursing scheduler (HIM) stated LPN-B was not well and was currently in a hospital intensive care unit, unavailable for interview. The HIM verified LPN-F had been a pool nursing staff.

During interview on 12/29/15, at 3:45 p.m. the acting administrator, who had been the DON at the time of the incident stated she'd thought R46's family had indicated he was admitted to the hospital with a bowel obstruction, but that it had later been found to be a narrowed bowel. The administrator was unable to recall specifics regarding R46's episode of illness; however, stated she would have expected staff to contact/call the on-call and/or primary physician directly with concerns that were urgent. The administrator stated she would have expected the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 157	Continued From page 7	F 157		

staff to check the vital signs, bowel movement status, appetite and fever status while conducting a physical assessment. The administrator stated she thought LPN-A was a good nurse and trusted her judgment. She further verified LPN-A worked every Thursday night shift.

When LPN-A was interviewed about the incident on 12/29/15 at 4:02 p.m., LPN-A stated she'd received report from the evening nurse (LPN-F) on 9/25/15, regarding R46's emesis, but had been unaware a fax had been sent. LPN-A stated she'd worked with R46 at least one time prior and was aware R46's vomiting and complaints of not feeling well was new for R46. She was aware R46 had thrown up and had not been eating well, and had subsequently administered Maalox during the night. LPN-A thought the Maalox had helped somewhat the first time she administered it (around 2:00 a.m.). LPN-A verified R46 had emesis of what looked like stool but there was no odor. She verified his abdomen had also seemed a little distended. LPN-A was unaware whether R46 had complained of pain. LPN-A said R46 subsequently vomited and it looked more like BM later in her shift (around 5:00 a.m.) at which time she'd become concerned that he may have something wrong with his small bowel. LPN-A said she'd proceeded to fill out all the transfer paperwork for a hospital discharge; however, did not call the RN on call nor notify the physician of her concern. LPN-A indicated she had passed along the paperwork and her concern to the day nurse, LPN-B, who arrived on duty at 6:00 a.m. on 9/26/25. LPN-A stated she'd told LPN-B to do an assessment to follow up on R46's condition. During the interview, LPN-A stated she thought there had been a history of small bowel concerns

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 157	Continued From page 8	F 157		

she had noted when filling out the paperwork to pass along to the day shift personnel.

During a follow up interview on 12/30/15, at 9:12 a.m. the administrator stated LPN-A should have notified the physician sooner about R46's symptoms, and that she had not been aware there had been a delay in his nursing care and physician notification of his condition.

During interview on 12/30/15, at 2:11 p.m. the medical director was interviewed and stated she would have expected nursing staff to call when they filled out the paperwork to transfer R46 to the hospital. The medical director stated although R46 may have subsequently expired anyway, prompt medical care would have made him comfortable. The medical director stated the effect of delayed medical care/interventions related to R46's medical outcome was difficult to state since she was not his usual physician.

During interview on 12/31/15, at 9:27 a.m. medical doctor (MD)-A (R46's usual physician) stated he would have expected staff to have called the clinic and/or the on-call physician when R46 began vomiting stool-like material. MD-A stated faxing medical staff at the clinic at 6:00 p.m. was inappropriate as the fax machine was not attended at that time of day. MD-A stated he'd been concerned about the potential for ischemic bowel when R46 arrived at the hospital, due to the delay in receipt of medical attention after his symptoms began. MD-A stated R46 had made some "depressed" comments prior to the hospital transfer on 9/26/15, but those comments were a "sidebar" and were not relevant to this issue. MD-A confirmed R46 would have been more comfortable if he had been examined

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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 157	Continued From page 9	F 157		

sooner in the ER. MD-A stated, "when you are vomiting brown stuff, it is probably a good idea if you are seen."

The facility's policy entitled Change in Condition SBAR last revised 3/15, indicated immediate notification of the physician was required for any symptom, sign or apparent discomfort that was sudden in onset, a marked change (i.e. more severe) in relation to usual signs and symptoms and was unrelieved by measures already prescribed. The policy further indicated in a section related to abdominal distension that immediate notification of the physician was required when there was rapid onset, or presence of marked tenderness, fever, vomiting or GI (gastrointestinal) bleeding.

Review of R21's Medication Administration Record (MAR) dated December 2015, identified that blood sugar (BS) readings were monitored five (5) times per day. Between the dates of 12/1 - 12/29/15 there were 44 blood sugar (BS) levels which were documented as 400 milligrams (mg)/ deciliter (dL) and above, with 25 of those documented BS level readings higher than 430 mg/dL. Although the resident's blood sugars fluctuated dramatically, there had not been physician notification of blood sugars which registered greater than 430 mg/dL.

A physician's order, dated 11/3/15 indicated, Insulin Regular Human Solution 100 unit/milliliter (ml) Inject as per sliding scale with the final ordered dosage "greater than 400 mg/dL: give 6 units".

A physician's order, dated 12/7/15 indicated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 157		F 157		

Continued From page 10
Insulin Glargine Solution 100 unit/ml- 24 units subcutaneous (SQ) one time per day (QD), and sliding scale with Regular Humalog solution 100 unit/ml. BS readings were to be faxed to the diabetic educator weekly. No parameters were listed for notification of the physician regarding hypo (low) or hyper (high) glycemia (BS).

During interview on 12/30/15, at 3:10 p.m. a licensed practical nurse (LPN)-C indicated there were no protocols, or orders, indicating when to notify the medical doctor (MD) of BS levels. LPN-C stated she would notify the MD related to how the resident felt and if there was a high BS-which she identified as "way above 400's-500's".

On 12/30/15, at 2:36 p.m. LPN-D stated she would notify the MD if she obtained a BS result above 600 mg/dL. LPN-D confirmed on 12/29/15, the supper BS check for R21 was 521 mg/dL and the MD was not updated. LPN-D further stated R21 frequently has BS readings above 400 mg/dL and the facility standing orders read to give 6 units of regular insulin if the BS was greater than 350 mg/dL. LPN-D indicated when the glucometer read "high" it was the result of a BS over 600 mg/dL and she would telephone the nurse on call at the hospital to report the reading.

During interview on 12/30/15, at 2:57 p.m. the diabetic educator indicated she received weekly reports of R21's BS results. She further stated the clinic has a protocol for diabetic medication adjustments and this was what insulin changes were based upon. The diabetic educator further stated R21 had a history of being a brittle diabetic and nursing staff were supposed to call the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 157	Continued From page 11	F 157		

medical provider on call and/or the triage nurse related to changes in status. The diabetic educator further indicated she thought BS parameters had been identified when R21 was recently discharged from the the hospital on 12/5/15. She indicated the parameters would have been determined by the discharging MD.

During interview on 12/30/15, at 3:12 p.m. RN-B and RN-C stated there were facility parameters for reporting BS readings. They referenced the documentation on the facility's standing orders and stated that would be the practice they followed unless individualized orders were written. RN-B indicated if a resident was symptomatic she would notify the physician based on the standing order instructions. RN -B and RN-C indicated they were not aware of the Change in Condition policy related to immediate reporting of BS readings above 430 mg/DL. RN-B stated, "we will have to make certain everyone is aware of this policy".

During interview on 12/31/15, at 8:36 a.m. LPN-E indicated she had been employed as an LPN for 3 months at the facility and had received training on BS checks which included: to test in a private area, wear gloves, and follow MD orders if the resident had orders for a sliding scale (SS), or a specific insulin order. LPN-E stated if there was a "high" reading she would contact the MD on call for direction. In the instance of a 400+ reading for R21 LPN-E indicated she would administer the ordered SS dose and recheck in one hour and then recheck in the following hour to determine whether the BS was responding to insulin. LPN-E stated she would probably not notify the MD in this instance as this resident has a history of BS fluctuations. LPN-E further indicated R21 did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 157	Continued From page 12	F 157		

have specific orders for follow up but this is what she would do.

On 12/31/15, at 9:04 a.m. R21's physician, also the facility's medical director, stated typically a resident would have a specific order that comes from the hospital for sliding scale insulin. R21's physician stated R21 had been her patient even before admission to the nursing home, and had a history of blood sugars fluctuating "all over" but that the resident was usually most comfortable when her blood sugars ran over 300 mg/dl. However, stated if she'd received a telephone call for an elevated blood sugar level she could provide specific orders as to when staff were required to recheck the BS and call back the results. She stated, "they call if the meter reads 'hi' because they have nothing to base it off. If the blood sugar is below 70 mg/dL staff would need to initiate the hypoglycemia protocol." She further indicated she would expect staff to notify the clinic and/or on-call staff to update on BS readings that were outside range.

When interviewed on 12/31/15, at 1:00 p.m. the director of nursing (DON) reviewed the December 2015 documentation of R21's BS readings and indicated she was unaware of the wide fluctuation of BS readings for R21 which were over 430 mg/dL. She confirmed she would have expected staff to notify the attending MD and/or the on-call staff in accordance with the Change in Condition When to Report to the MD/NP/PA policy.

The facility's policy related to physician notification for blood sugar fluctuations, entitled, Change in Condition When to Report to the MD/nurse practitioner(NP)/physician assistant last revised 3/15, included: "blood sugars greater

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 157	Continued From page 13 than 430 mg/dL (or machine registers high) in diabetic patients using sliding scale insulin should be immediately reported to the physician or nurse practitioner (NP)."	F 157		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the most current survey results were posted in an area readily accessible to residents, families and visitors. This had the potential to affect all 40 residents currently residing in the facility. Findings include: During the initial tour of the facility with the director of nursing (DON) on 12/28/15, at 12:00 p.m., observations revealed the current federal and state survey results were not available to residents, families or visitors. The DON indicated the results are usually posted on the bulletin board near the north and south nurses stations, but confirmed they were not in that location. After	F 167	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Posting the most current survey results in an area readily accessible to residents, families and visitors. 2. All residents, families and visitors will have access to the most current survey	2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 167	Continued From page 14 15 minutes of looking for the survey results, the DON found them to be in a 3- ring binder placed behind the south nurses station in the resident chart stand. The binder which included the survey results was not visible nor easily accessible to the residents, families or visitors. The DON confirmed this.	F 167	results. 3. Education will be completed by 2-5-16 at an all staff meeting in regards to posting the most current survey results and the importance of the location designated for the current survey results. 4. The Administrator or designee will ensure that the most current survey results are posted in the designated location. The Administrator or designee will do audits 5 times per week for 1 month, then audits three times a week for 2 months to ensure that the facilities plan of correction is being followed. 5. The data collected will be reviewed/discussed at the quarterly QA&A meeting. At that time the QA&A committee will make the decision/recommendation regarding any follow-up studies. The Administrator will be responsible for this POC. Completion date: 2-8-16	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the safe practice of self-administration for 1 of 2 residents	F 176	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted	2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 176	Continued From page 15 (R6) who were observed self- administering a nebulizer treatment. Findings include: R6's physician orders dated 12/8/15, included Ipratropium-Albuterol solution 0.5-2.5 (3) milligrams/3 milliliters, 1 vial inhale orally three times a day for shortness of breath, every 6 hours while awake. R6's annual Minimum Data Set (MDS) dated 10/9/15, indicated R6 had severe cognitive impairment. Review of R6's care plan dated 10/12/15 included a risk for alteration in respiratory status related to (r/t) diagnoses of emphysema/COPD (chronic obstructive pulmonary disease) with recurrent acute episode. History of (h/o) pneumonia, and h/o bronchospasms (sudden constriction of the muscles in the walls of the bronchioles causing difficulty breathing). The care plan further identified a behavior problem r/t dementia which included routinely refusing neb (nebulizer) treatments. Further review of the medical record did not include evidence of an assessment related to R6's ability to self-administer medications. On 12/29/15, at 2:39 p.m. two surveyors observed R6 sitting on the edge of his bed wearing a nebulizer mask with machine running and medication noted in the nebulizer solution receptacle. R6 was alone in the room with no staff present within visualization of the resident. On 12/29/15, at approximately 2:50 p.m. licensed	F 176	as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Resident # 6 was transferred to another facility on 1-25-16. 2. All residents for whom nebulizer treatments are ordered have been reviewed to ensure that nursing staff are remaining with them during their breathing treatments. 3. Education will be completed by 2-3-16 for all Licensed Nursing staff on administration of nebulizer treatments that include remaining with the resident during the entire nebulizer treatment. A clinical Competency by Licensed Nursing Staff will be completed. Each nurse, when signing for completion of the nebulizer treatment for each resident receiving one in the MAR, will be trained that by signing, they not only verify that they performed the nebulizer treatment procedure for the resident but that their signature also verifies that they remained with the resident during the course of the nebulizer treatment as a necessary part of the procedure. 4. The DNS or designee will complete two audits per week for four weeks then weekly for two months to ensure compliance. 5. The data collected will be reviewed/discussed at quarterly QA&A	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 176	Continued From page 16 practical nurse (LPN)-D was observed in R6's room. R6 was sitting on the edge of bed though no longer had the nebulizer mask on nor was the machine running. When interviewed on 12/31/15, at 9:09 a.m. the director of nursing (DON) confirmed R6 did not have an assessment to self administer medications; the medication nurse was expected to remain with the resident throughout a nebulizer treatment. The DON further confirmed C6 had a history of being non-compliant with administration of nebulizer treatments. The facility policy/procedure titled, Nebulizers included: "10. Monitor the resident throughout the treatment."	F 176	meeting. At this time the QA&A committee will make the decision/recommendation regarding any follow-up studies. The DNS is responsible for the POC. Completion Date: 2-8-16	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide activities for 2 of 3 (R6, R23) residents reviewed for activities. Findings include: R6 R6 was admitted to the facility on 9/5/14, with diagnoses including dementia without behavioral	F 248	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and	2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 248	Continued From page 17	F 248		

disturbance, cognitive communication deficit, chronic obstructive pulmonary disease (COPD), muscle weakness and difficulty walking per the facility diagnosis report.

R6's annual Minimum Data Set (MDS) assessment dated 10/9/15, indicated severely impaired cognition with daily wandering that significantly intruded on the privacy of others, physical behavior towards others 1-3 days, other behavior not directed towards others 4-6 days but less than daily. The MDS further indicated neither the resident nor family/significant other could complete the daily and activity preference portion of the assessment. The staff assessment of daily and activity preferences indicated the resident preferred receiving a tub bath, snacks between meals, staying up past 8:00 p.m., family or significant other involvement in care discussions, listening to music and spending time outdoors.

R6's annual Recreation/Wellness Assessment dated 10/4/15, indicated information was given by R6's son from the previous assessment. The assessment identified current interests as: group participation in intergeneration programs with specific interest with school kids singing, golf cart rides, visiting in person/on phone with family, walks/bicycling. The assessment also included past preferences of watching wrestling on TV and Charlie Chan movies.

R6's care plan for activities dated 10/12/15, indicated the resident was primarily independent but occasionally needed some guidance with structuring leisure activities that promote wellness. Interventions identified on the care plan:

federal law require it. Without waiving the foregoing statement, the facility states with respect to:

1. Resident s #6 and resident #23 s recreation/wellness assessment have been reviewed and their care plans for activities have been updated which includes more specific activities that are appropriate for them.
2. All residents will be reviewed by the Activity department to ensure that appropriate activities are in place for each of them.
3. Education on resident appropriate activities will be completed by 2-5-16 at an all staff meeting. The activity department will create a daily activity log to ensure that appropriate activities are in place for each resident. Where difficulties may exist regarding appropriate activities for specific residents who are more challenging, the IDT will be enlisted to help develop a plan for appropriate activities.
4. The Activity Director or designee will complete 2 audits weekly for 4 weeks and weekly for 2 months to ensure that the resident s are receiving activities according to their plan of care.
5. The data collected will be reviewed/discussed at the quarterly QA&A meeting. At this time the QA&A committee will make the decision/recommendation regarding any follow-up studies.

The Activity Director and MDS Coordinator will be responsible for this POC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 248	Continued From page 18 (1.) CD player in room; please play music per resident's desire. (2.) Recreation/Wellness preferences include: exercise, listening to music, watching TV (enjoys wrestling and war movies) food related activities, sensory and 1:1 time. (3.) EMOTIONAL: Offer ipod or CD player for individual music enjoyment. (4.) PHYSICAL: Encourage participation in Well-Fit program to include group exercise and/or individual cardio. The activity goal indicated R6 would work on puzzles in day room by the review period. When interviewed on 12/29/15, at approximately 8:50 a.m. the director of nursing (DON) confirmed R6 did not speak or understand English. DON further indicated staff communicated with the resident through gestures and facial expressions. Continuous observations of R6 on 12/29/15, from 1:16 p.m. until 4:17 p.m., revealed the following: - At 1:16 p.m. R6 was ambulated with the assistance of two staff, a 3rd staff pushed the residents wheelchair (w/c) behind him down the west Cityside hallway. Staff were responding in English to his vocalizations. After R6 ambulated the length of the hall staff seated him back in the w/c, removed the transfer belt and transferred him to the dayroom area located by the nurses' station. Staff moved him in front to the television and then R6 propelled himself in the w/c throughout the dayroom. - At 1:27 a.m. nursing assistant (NA)-A brought R6 a round shaped sensory item which consisted of multiple-colored hollow tubes held together with a bungy type cord. This enabled the object to	F 248	Completion date 2-8-16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 248	Continued From page 19 be stretched and manipulated. R6 accepted the item, talking out loud constantly. Although R6 held the item, he did not appear interested nor did he attempt to manipulate or pull the sensory item. NA-A left the area after the item was delivered to R6. R6 remained in the commons area until 1:44 p.m., when licensed practical nurse (LPN)-C assisted him back to his room. -At 1:52 p.m. R6 left his room via the w/c to obtain water in his plastic mug from the drinking fountain located in the west hallway. Staff assisted him with the task, replaced the lid and left the area. With a water-filled mug, R6 continued to vocalize as he propelled the w/c down the west hallway. It was noted that once R6 arrived at the end of the hallway, staff intercepted and returned him back to his room. -At 2:00 p.m., R6 was observed lying in bed on top of covers with shoes on. The sensory item given to him earlier was placed on his legs. R6 was not touching nor handling the item even though he appeared to be wide awake. At this time, a popcorn and movie activity was occurring in the activity room, however R6 was not assisted to attend. At 2:14 p.m. staff entered the room to distribute fresh water, greeted R6 and left immediately. -At 2:30 p.m., R6 was seated on the edge of his bed in room with the left shoe off and was holding a shoe on his lap, removing the laces. The sensory object was no longer visualized. No music was playing in the room. From 2:39 until 4:17 p.m., R6 was observed attempting to remove and replace the lace from his left shoe. Although coffee social, wellness group and word games activities were held in the dining room at	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 248	Continued From page 20	F 248		

this time, R6 was not assisted or offered to attend. At 3:10 p.m. NA-C entered the room and greeted R6. Trained medication aide (TMA)-A also entered the room and asked whether R6 was still "working on his shoe". NA-C asked TMA-A whether R6 was supposed to have the shoe. TMA-A responded that if NA-C could get it laced and on R6, they could transfer him into his chair and not worry about it, however NA-C did not assist R6.

Observations of R6 on 12/30/15 revealed the following:
- At 7:50 a.m. R6 was observed seated alone at a table in the corner of the dining room eating breakfast independently. The table was pushed flush to the wall on 2 sides. R6 had his back to the other resident's in the dining room, facing only the wall. At 7:58 a.m. R6 was assisted in the w/c by staff to the Cityside dayroom and placed at a table. Staff handed R6 a multicolored cylinder shaped sensory object that also made sound when manipulated. Staff then left the area without further interaction. R6 placed the object behind him on the seat of his w/c and proceeded to propel self past the nurses' station towards the dining room to the medication cart where LPN-C was standing. R6 vocalized loudly. LPN-C responded to R6 that he had already eaten and assisted in propelling him back to his room. LPN-C left the resident's room at 8:05 a.m. R6 was lying on his bed with the bare mattress exposed and bedding in a clump at the end of bed; no pillowcase was on R6's pillow. R6 was observed holding onto the grab bar, attempting to sit up in bed.

-At 10:04 a.m. a church activity was conducted in the activity room. R6 independently propelled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 248		F 248		

Continued From page 21

himself down the west hallway but once R6 turned the corned, the administrator redirected and propelled him back down the direction of the hallway. R6 then entered the dayroom, propelling self around the perimeter of the area, pausing to look out the window and then watched the activity in the fish tank. R6 propelled himself toward the direction of the east hallway and remained seated near this area until 10:30 a.m. LPN-C then moved R6 from the east hallway to a table located in the dayroom. No verbal communication nor interaction was noted between staff and R6. R6 was not offered/assisted to the church activity at anytime throughout the noted observations nor did staff interact with the resident.

-At 11:07 a.m. R6 was observed seated in w/c in dayroom by nurses station; Wellness activity was currently in process and was identified on the plan of care as an planned intervention. At 11:27 a.m. R6 was seated in w/c in Cityside dayroom near nurses station when the activity director (AD) entered the dayroom, said "Hi" to R6, turned up the volume on the TV and walked away.

-At 2:35 p.m. R6 was observed in the dining room where the men's group activity was held in the main area of the dining room. No activity staff were noted to interact with R6 until they assisted out of the dining room towards the direction of his room at 2:44 p.m.

When interviewed on 12/30/15, at 12:41 p.m. the AD stated R6 is very "antsy" r/t group activities and is scheduled for in-room programming. AD further indicated that 2 in-room activity programs were scheduled for 20 minutes/day. AD also stated staff will also offer coffee social time as well as the men's group activity as well as three

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 248	Continued From page 22	F 248		

1:1 visits weekly. AD confirmed there was a language barrier related to attending activities and that an interpreter from the high school came to the facility on 12/4/15 but had not returned since. AD stated trying to get hold of the interpreter but calls had not been returned. AD stated a few weeks ago a representative from another facility came to assess the resident for possible placement. The representative was able to converse with R6 in his native language and discovered he enjoyed weaving baskets.

When requested documentation related to activities provided for R6, the following was noted: (11/2/15 thru 12/12/15) -R6 received only two 1:1's with staff (11/4 & 11/7). The week of 11/16-11/22/15 R6 received 1:1 activity. Although the AD indicated she had provided 1:1 in-room programming with R6, she was unable to provide documentation to demonstrate this had been implemented nor could she recall when this had occurred. AD stated she offered an Ipod with headphones for R6 to listen to music in his own language. The AD then provided documentation indicating the Ipod was offered 5 times in November and 4 times in December 2015. When questioned about the preferred activities (wrestling and war movies) documented on R6's care plan, she indicated being unaware of these preferences. When the current activity sheets were reviewed to substantiate the activities each resident had attended, there was nothing highlighted and/or documented indicating that R6 had been involved in activities during the days of observations.

When further interviewed on 12/31/15, at 10:21 a.m. the AD was unable to provide documentation of activities offered in 11/15 and provided 5 days

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 248	Continued From page 23	F 248		

of activity sheets for 10/15, and provided only ten days of documentation for 12/15. The sheets indicated R6 attended exercise on 12/21/15, and the AD stated he did really well with it. The activity sheets failed to document whether R6 had participated, wandered away and/or refused the activity; the AD confirmed the activity documentation was incomplete.

R23
R23 was admitted on 1/6/15 with diagnoses including: dementia, paranoid personality, mood disorder, and chronic obstructive pulmonary disease (COPD) per the facility diagnosis report. The report further identified R23 was admitted to hospice services on 5/15/15 due to senile degeneration of the brain.

R23's quarterly Minimum Data Set (MDS) assessment dated 11/6/15, indicated R23 severely impaired cognition, total dependence with locomotion on/off unit, and extensive assistance with bed mobility, transfer, eating, toilet use, and personal hygiene.

R23's significant change MDS assessment dated 5/6/15, indicated activity preferences as: very important to have books, magazines, newspapers to read, very important to do favorite activities, very important to go outside and get fresh air when weather is good, and very important to participate in religious services or practices.

R23's care plan last revised 11/9/15, indicated the resident was dependent on staff for structuring and providing activities that promote wellness stimulation due to cognitive deficits. Interventions included: (1) "1 to 1 bedside/in-room visits and activities if [resident name] is unable to attend out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 248	Continued From page 24	F 248		

of room events. (2) COGNITIVE: Encourage participation in small groups and/or 1:1 interactions (3) EMOTIONAL: Offer ipod or CD player for individual music enjoyment. (4) ENVIRONMENTAL: Observe [resident name] body language related to over stimulation [Resident name] Recreation/Wellness individual preferences include Bingo, walks, magazines, word search, TV and listening and playing music."

R23 was observed continuously on 12/29/15, from 1:14 p.m. until 3:56 p.m. while lying in bed. A popcorn and move activity was held at 1:30 p.m. in the activity room and the coffee social activity held at 2:30 p.m. in the dining room. Staff did not offer R23 the opportunity to attend either activity.

R23 was again observed continuously on 12/30/15, from 10:03 a.m. until 10:23 a.m. At 10:03 a.m. R23 was seated in a geri chair in the Cityside dayroom at a table while a church service was currently being held in the activity room.

At 10:21 a.m. R23 remained in the geri-chair with eyes closed. The AD approached another resident seated in w/c located near the Cityside nurses station and asked whether she wanted to attend church. R23 opened her eyes when the AD and the resident left for church but looked away and closed her eyes when they left the area. NA-A then approached R23 at 10:23 a.m. to ask whether she wanted to lay down. R23 nodded "yes". NA-A did not give her the opportunity to attend the church activity before transporting her to her room.

At 11:08 a.m. R23 was observed lying in bed with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 248	Continued From page 25	F 248		

eyes closed while a Wellness activity was in process. She had not been given the opportunity to attend this activity.

At 3:12 p.m. R23 was again lying in bed with eyes closed. A music activity was being performed in the Cityside dayroom with a resident's family member piano playing. Staff were not observed to offer attendance to the activity to R23.

When interviewed on 12/30/15, at 11:55 a.m. NA-B and NA-A confirmed they had assisted R23 with her morning cares, stating that when offered activities, she often refuses as prefers to lie down. Both NA's confirmed they had not offered R23 attendance at the morning church activity as R23 had been tearful that morning when receiving care and they felt the resident would rather lie down. NA-B further stated the resident liked to color when first admitted and will attend church though at times will become disruptive during the service.

When interviewed on 12/30/15, at 1:40 p.m. the AD stated R23's activities included hair care, a daily Sunshine group (sensory group) which is implemented twice daily Monday-Friday and once on Saturdays). AD stated the resident usually does fine while attending church service but sometimes needed to be removed from the service as would get agitated. AD confirmed she would still expect R23 be offered the opportunity to participate in attending church. AD attempted to located documentation of activities attended and 1:1's provided for R23. The 1:1 activity sheets indicated R23 was to have 1:1's three times/weekly. AD provided 1:1 documentation from 11/2/15 - 12/5/15 (minus the week of 11/16/15 - 11/22/15); R23 was provided a 1:1 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 248	Continued From page 26 7 occasions during this period (11/5/15, 11/7/15, 11/12/15, 11/13/15, 11/27/15, 12/4/15, 12/7/15). AD confirmed the 1:1 charting was inadequate and did not identify the activity, time and/or response. Staff would not be able to evaluate effectiveness of planned interventions. When interviewed on 12/31/15, at 10:21 a.m. the AD provided 10 days of December 2015 activity sheets for R23. The sheets indicated R23 was offered activities on 5 of the 10 days. AD was unable to provide documentation of activities offered in November 2015 and provided 5 days of activity sheets for October 2015. The activity sheets did not include evidence if the resident had participated or refused the activity; AD confirmed the charting of activities was incomplete. .	F 248		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 282 SS=D	Continued From page 27 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care related to activities for 2 of 3 (R6, R23) residents reviewed for activities. Findings include: R6 When interviewed on 12/29/15, at approximately 8:50 a.m. the director of nursing (DON) confirmed R6 did not speak or understand English. DON further indicated staff communicated with the resident through gestures and facial expressions. R6 was admitted to the facility on 9/5/14, with diagnoses including dementia without behavioral disturbance, cognitive communication deficit, chronic obstructive pulmonary disease (COPD), muscle weakness and difficulty walking per the facility diagnosis report. R6's care plan for activities dated 10/12/15, indicated the resident was primarily independent but occasionally needed some guidance with structuring leisure activities that promote wellness. Interventions identified on the care plan: 1. CD player in room; please play music per resident's desire.	F 282	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Resident #6 and Resident #23 plan of care related to activities was reviewed and updated to meet their individualized needs. 2. All residents are assessed for their activity preferences upon admission, quarterly and with a significant change in condition and care plans are updated to ensure appropriate interventions are implemented. All Residents have had their care plans reviewed to ensure that each of them are receiving appropriate activities. A special care plan meeting hosted by the Activities Director will be conducted quarterly to ensure that activities are being instituted and conducted in accordance with proper care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 282	Continued From page 28 2. Recreation/Wellness preferences include: exercise, listening to music, watching TV (enjoys wrestling and war movies) food related activities, sensory and 1:1 time. 3. EMOTIONAL: Offer ipod or CD player for individual music enjoyment. 4. PHYSICAL: Encourage participation in Well-Fit program to include group exercise and/or individual cardio. The activity goal indicated R6 would work on puzzles in day room by the review period. On 12/29/15, R6 was observed continuously from 1:16 p.m. until 4:17 p.m. - At 1:16 p.m. R6 was ambulated with the assistance of two staff, a 3rd staff pushed the residents wheelchair (w/c) behind him down the west Cityside hallway. After R6 ambulated the length of the hall staff seated him back in the w/c, removed the transfer belt and transferred him to the dayroom area located by the nurses' station. Staff moved him in front to the television and then R6 propelled himself in the w/c throughout the dayroom. -At 1:27 a.m. nursing assistant (NA)-A brought R6 a round shaped sensory item which consisted of multiple-colored hollow tubes held together with a bungy type cord. This enabled the object to be stretched and manipulated. R6 accepted the item, talking out loud constantly. Although R6 held the item, he did not appear interested nor did he attempt to manipulate or pull the sensory item. NA-A left the area after the item was delivered to R6. -At 1:34 p.m. a staff member transported R6 from the middle of the dayroom to a table with another	F 282	planning; this special meeting will be documented and will involve members of the IDT. This meeting will be in addition to care plan updates on admission, quarterly, and on change in condition. 3. Education will be completed by 2-5-16 for all staff on following interventions care planned for all residents. 4. The DNS or designee will complete two audits per week for 4 weeks and then weekly for two months to ensure compliance in these areas. 5. The data collected will be reviewed/discussed at the quarterly QA&A meeting. At this time the QA&A committee will make the decision/recommendation regarding any follow-up studies. The DNS and Activity Director will be responsible for this POC. Completion Date: 2-8-16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 282	Continued From page 29 resident. R6 continued to verbalize while the sensory object remained on his lap. No interaction between staff and R6 occurred. R6 remained at the table a short time and then began to propel the w/c around the dayroom. -At 2:00 p.m., R6 was observed lying in bed on top of covers with shoes on. The sensory item given to him earlier was placed on his legs. R6 was not touching nor handling the item even though he appeared to be wide awake. At this time, a popcorn and movie activity was occurring in the activity room. -At 2:07 p.m. it was noted that R6 was sitting up on edge of bed with feet dangling down; the sensory item remained on resident's lap. It was again noted that R6 was not touching nor interested in this sensory object. -At 2:30 p.m., R6 was seated on the edge of his bed in room with the left shoe off and was holding a shoe on his lap, removing the laces. The sensory object was no longer visualized. No music was playing in the room. -At 2:39 p.m., R6 remained seated at the edge of the bed attempting to pull the laces from his left shoe. R6 had a nebulizer mask on and no staff were present in the room during this observation. Coffee social and word games activities were held in the dining room at this time. -At approximately 2:50 p.m., LPN-D in R6's room attending to the nebulizer machine while R6 continued to sit on edge of bed attempting to remove the laces from his left shoe. At 2:56 p.m. R6 remained seated at the edge of bed holding onto the unlaces left shoe. At 3:10 p.m. NA-C	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 282	Continued From page 30	F 282		

entered the room and greeted R6. Trained medication aide (TMA)-A also entered the room and asked whether R6 was still "working on his shoe". NA-C asked TMA-A whether R6 was supposed to have the shoe. TMA-A responded that if NA-C could get it laced and on R6, they could transfer him into his chair and not worry about it. On 12/29/15, at 3:57 p.m. R6 remained seated on the side of bed, holding his left shoe without laces. R6 appeared to be examining the shoe. The Wellness group was on the activity schedule for 4:00 p.m. At 4:17 p.m. R6 remained seated on edge of bed, holding onto the left shoe and was attempting to replace the laces back in the shoe. This activity had been continuous since 2:30 p.m. (almost 2 hours).

R6 was not offered/assisted to scheduled activities during the 3 hours of continuous observation on 12/29/15. The plan of care was not followed as written. R6 was handed a sensory object though staff failed to model how object could be used and/or spend time any time with R6.

It was observed on 12/30/15, at 10:04 a.m. a church activity was conducted in the activity room. R6 independently propelled himself down the west hallway but once R6 turned the corned, the administrator redirected and propelled him back down the direction of the hallway. R6 then entered the dayroom, propelling self around the perimeter of the area, pausing to look out the window and then watched the activity in the fish tank. R6 propelled self toward the direction of the east hallway and remained seated near this area until 10:30 a.m. LPN-C then moved R6 from the east hallway to a table located in the dayroom. No verbal communication nor interaction was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 282	Continued From page 31 noted between staff and R6. R6 was not offered/assisted to the church activity at anytime throughout the noted observations nor did staff interact with the resident. On 12/30/15, at 11:07 a.m. R6 was observed seated in w/c in dayroom by nurses station; Wellness activity was currently in process and was identified on the plan of care as an planned intervention. At 11:27 a.m. R6 was seated in w/c in Cityside dayroom near nurses station when the activity director (AD) entered the dayroom, said "Hi" to R6, turned up the volume on the TV and walked away. At 2:35 p.m. R6 was observed in the dining room where the men's group activity was held in the main area of the dining room. R6 was served a snack while located in the front area of the main dining room, partitioned off by a wall with 2 openings. R6 was offered his snack at the table where he routinely consumed his meals. R6 was left alone in the front area of the dining room while the other residents were served their snack in the main area. At 2:41 p.m. when R6 finished his snack, propelled himself around the front area of the dining room near his designated table. No activity staff were noted to interact with R6 until they assisted out of the dining room towards the direction of his room at 2:44 p.m. When interviewed on 12/30/15, at 12:41 p.m. the AD stated R6 is very "antsy" r/t group activities and is scheduled for in-room programming. AD further indicated that 2 in-room activity programs were scheduled for 20 minutes/day. AD also stated staff will also offer coffee social time as well as the men's group activity as well as three 1:1 visits weekly.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 282	Continued From page 32	F 282		

When questioned about the preferred activities (wrestling and war movies) documented on R6's care plan, she indicated being unaware of these preferences. When the current activity sheets were reviewed to substantiate the activities each resident had attended, there was nothing highlighted and/or documented indicating that R6 had been involved in activities during the days of observations.

When further interviewed on 12/31/15, at 10:21 a.m. the AD provided 10 days of December 2015 activity sheets which indicated R6 was offered activities on 8 of the 10 days. AD stated the activity sheet dated 12/21/15, indicated the resident was offered the exercise activity. AD stated she sat next to R6 during the activity and he did really well. However, the AD was unable to provide documentation of activities offered in November 2015 and provided 5 days of activity sheets for October 2015. It was confirmed the plan of care was not implemented as written.

R23
R23 was admitted on 1/6/15 with diagnoses including: dementia, paranoid personality, mood disorder, and chronic obstructive pulmonary disease (COPD) per the facility diagnosis report. The report further identified R23 was admitted to hospice services on 5/15/15 due to senile degeneration of the brain.

R23's care plan last revised 11/9/15, indicated the resident was dependent on staff for structuring and providing activities that promote wellness stimulation due to cognitive deficits. Interventions included: (1) "1 to 1 bedside/in-room visits and activities if [resident name] is unable to attend out of room events. (2) COGNITIVE: Encourage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 282	Continued From page 33	F 282		

participation in small groups and/or 1:1 interactions (3) EMOTIONAL: Offer ipod or CD player for individual music enjoyment. (4) ENVIRONMENTAL: Observe [resident name] body language related to over stimulation [Resident name] Recreation/Wellness individual preferences include Bingo, walks, magazines, word search, TV and listening and playing music."

R23 was observed continuously on 12/29/15, from 1:14 p.m. until 3:56 p.m. while lying in bed. A popcorn and move activity was held at 1:30 p.m. in the activity room and the coffee social activity held at 2:30 p.m. in the dining room. Staff did not offer R23 the opportunity to attend either activity.

R23 was again observed continuously on 12/30/15, from 10:03 a.m. until 10:23 a.m. At 10:03 a.m. R23 was seated in a geri chair in the Cityside dayroom at a table while a church service was currently being held in the activity room.

At 10:21 a.m. R23 remained in the geri-chair with eyes closed. The AD approached another resident seated in w/c located near the Cityside nurses station and asked whether she wanted to attend church. R23 opened her eyes when the AD and the resident left for church but looked away and closed her eyes when they left the area. NA-A then approached R23 at 10:23 a.m. to ask whether she wanted to lay down; R23 nodded "yes". NA-A did not give her the opportunity to attend the church activity before transporting her to her room.

At 11:08 a.m. R23 was observed lying in bed with eyes closed while a Wellness activity was in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 282	Continued From page 34	F 282		

process. She had not been given the opportunity to attend this activity.

At 3:12 p.m. R23 was again lying in bed with eyes closed. A music activity was being performed in the Cityside dayroom with a resident's family member piano playing. Staff were not observed to offer attendance to the activity to R23.

When interviewed on 12/30/15, at 11:55 a.m. NA-B and NA-A confirmed they had assisted R23 with her morning cares, stating that when offered activities, she often refuses as prefers to lie down. Both NA's confirmed they had not offered R23 attendance at the morning church activity as R23 had been tearful that morning when receiving care and they felt the resident would rather lie down.

When interviewed on 12/30/15, at 1:40 p.m. the AD stated R23's activities included hair care, a daily Sunshine group (sensory group) which is implemented twice daily Monday-Friday and once on Saturdays). AD confirmed she would still expect R23 be offered the opportunity to participate in attending church. AD attempted to located documentation of activities attended and 1:1's provided for R23. The 1:1 activity sheets indicated R23 was to have 1:1's three times/weekly. AD provided 1:1 documentation from 11/2/15 - 12/5/15 (minus the week of 11/16/15 - 11/22/15); R23 was provided a 1:1 on 7 occasions during this period (11/5/15, 11/7/15, 11/12/15, 11/13/15, 11/27/15, 12/4/15, 12/7/15).

When interviewed on 12/31/15, at 10:21 a.m. the AD provided 10 days of December 2015 activity sheets for 23. The sheets indicated R23 was offered activities on 5 of the 10 days. AD was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 282	Continued From page 35 unable to provide documentation of activities offered in November 2015 and provided 5 days of activity sheets for October 2015. The activity sheets did not include evidence if the resident had participated or refused the activity; AD confirmed the charting of activities was incomplete. The plan of care was not implemented as written.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate nursing care and services for 2 of 4 residents (R46, R21) reviewed who had been hospitalized. This resulted in actual harm for R46, who experienced prolonged discomfort, dehydration and vomiting related to delayed nursing assessment and transfer to an inpatient facility for a small bowel obstruction. In addition, the facility failed to provide appropriate interventions related to dementia care for 1 of 1 resident (R6) reviewed who had dementia and could not speak/understand English. Findings include:	F 309	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Resident #46 is deceased. The facility found a more appropriate placement for resident #6. This facility has Hmong speaking staff. This resident	2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 309	Continued From page 36	F 309		

R46's discharge orders to the nursing home dated 9/17/15, identified a discharge condition of improving with orders for physical and occupational therapy.

R46's physician's progress notes, dated 9/18/15 indicated diagnoses of spinal stenosis of the lumbar region, sepsis, and urinary tract infection. The physician's progress note also identified a history of diverticulitis of the colon.

R46's admission Minimum Data Set (MDS), dated 9/24/15 identified a Brief Interview for Mental Status score of 13/15 (cognitively intact). No care area assessments were completed with the MDS.

R46's care plan, dated 9/30/15 identified no cognitive impairments and that R46 desired to return to the community.

R46's September 2015 medication sheets revealed R46 had received Maalox (an antacid) 30 cubic centimeters (cc)'s on 9/25/15 a total of four times on that date, as well as one dose at 2:00 a.m. on 9/26/15. Notations documented by licensed practical nurse (LPN)-A, on the back of the medication administration record for a dose administered on 9/25/15, at 2:00 a.m. indicated the medication had been given for stomach upset since supper. No follow up assessment for effectiveness was completed. A subsequent entry dated 9/26/15, at 2:00 am. indicated R46 had received another dose of Maalox for an upset stomach and emesis; the follow up result was listed as had another emesis at 4 a.m. None of the other doses administered had follow up results documented.

A nursing progress note written by LPN-F on

Provider's Plan of Correction (F 309):

will be closer to his family and be placed in a dementia unit that is a quieter setting as recommended by his primary physician.

2. All residents have been reviewed to ensure that any non-English speaker has someone in the facility who speaks their language. All residents have been reviewed for any significant change in condition and need to notify the physician and DNS.
3. Education to licensed staff will be completed by 2-3-16 on significant change in resident condition, physician notification per phone call and DNS notification with any change in resident condition and the importance of having someone available to speak the language of all non-English speaking residents.
4. Nurses will notify the physician immediately (in a timely manner) when residents have a significant change in condition and they will also notify the Director of Nursing. They will no longer use fax to communicate these serious issues regarding residents. Prior to admission the facility will ensure that there is someone available who speaks the language of any non-English speaker.
5. The DNS or designee will complete 2 audits weekly for 4 weeks and weekly for 2 months to ensure that the facilities guideline is being followed correctly.
6. The data collected will be reviewed/discussed at the quarterly QA&A meeting. At this time the QA&A committee will make the decision/recommendation regarding any follow-up studies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 309	Continued From page 37 9/25/15 at 8:30 a.m., indicated R46 had hiccups and complaints of not feeling well. The notes indicated R46 had been given Maalox 30 cc's along with Thorazine and had begun retching after his morning medications. In addition, R46 had experienced a large projectile emesis all over the bed and himself, and had refused to eat anything for breakfast, stating he had consumed orange juice that had all come up. A nursing progress note documented by LPN-F on 9/25/15, at 1:39 p.m. indicated R46 had a large emesis, and that the resident had stated he was not feeling well. The notes indicated his hiccups had subsided for a while but had then started again. Documentation indicated R46 had received Maalox and Thorazine (an antipsychotic medication used for antiemetic properties) with another small emesis afterward. The emesis was documented as having had food particles present and was described as having a colicky odor. R46's temperature was documented as having been elevated at 99.0 degrees Fahrenheit (F). A nursing progress note dated 9/25/15, at 6:00 p.m. per LPN-F indicated R46 had stayed in bed most of the evening. The note indicated R46's hiccups were better over the early evening hours but that R46 had been stated his tummy still didn't feel right and that whenever he moved he began to gag. R46 had eaten Jell-O for supper and had sips of water. Additionally, the documentation indicated a fax (facsimile) had been sent to medical doctor (MD)-A with an update on R46's condition including that R46 had an elevated temperature at 99.5 degrees F and complained of feeling chilly. A nursing progress note dated 9/25/15, at 11:05	F 309	The DNS is responsible for this POC. Completion Date: 2-8-16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 38	F 309		

p.m. per LPN-F indicated R46 had not been feeling well, and had been having brown colored emesis twice on the afternoon shift which did not appear to have a feces odor. Maalox 30 cc's had been given to help with hiccups and R46's vitamins had been held due to emesis.

A nursing progress note by LPN-A, dated 9/26/15, at 1:56 a.m. indicated R46's abdomen was distended, his bowel sounds were difficult to hear and he had been having emesis which looked like BM. R46's temp was noted to be slightly elevated at 99.1 degrees F.

A nursing progress note written by LPN-A on 9/26/15, at 4:48 a.m. indicated R46 had 100 cc's of emesis, like soft formed/loose BM (bowel movement) with no odor. The note further indicated R46 was cool and clammy, with a slightly elevated temperature at 99.1 degrees F. R46 had a wastebasket beside him, and continued to wretch.

A nursing progress note entered by LPN-B, dated 9/26/15, at 9:57 a.m. indicated R46 had two further emesis of greenish liquid thick with pieces of BM looking in it. In addition, the note indicated an acute care hospital had been called and an order was received to transfer R46 to their emergency room (ER) via ambulance. The note indicated R46's daughter was updated and had agreed to meet him at the hospital. R46 left the facility at 8:45 a.m.

A faxed physician's order dated 9/26/15 was present in R46's record and verified the physician order to transfer per ambulance to the acute care hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 39	F 309		

An additional nursing progress note dated 9/26/15, at 2:06 p.m. indicated R46 had been admitted to the acute care hospital with a diagnoses of bowel obstruction, and would need surgery.

A faxed physician's order sent on 9/25/15, at 6:05 p.m. from the facility to R46's primary physician identified that R46 had emesis since 8:30 a.m., experienced several rounds of hiccups throughout the day and had been unable to eat or drink. R46 complained of feeling weak. The fax had not been signed off until on 9/28/15, three days later, when the nurse practitioner (NP)-A responded with a statement including, "Noting telephone order to transfer to ER on 9/26/15. Please do NOT fax in regard to situations that need attn [attention] that day. This will be sent to [physician] - today 9/28/15. Please review the faxing for response procedure. Thx [Thanks]."

The ER progress note dated 9/26/15, at 10:36 a.m. was reviewed. The ER note indicated R46 had appeared distressed when examined, had been uncomfortable, and had dry oral mucous with dried brown material on the tongue and lips. The ER note further indicated R46's abdomen was firm and diffusely distended, mildly tender with no appreciable bowel sounds. In addition, 1800 milliliters (ml) of brown liquid had been drained from R46's stomach after the insertion of a nasogastric tube. R46 had received 2000 ml of normal saline intravenous for hydration. The ER physician's note indicated R46 had appeared quite dehydrated and verified the admitting diagnoses of small bowel obstruction and severe dehydration.

The ER registered nurse's assessment dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 40	F 309		

9/26/15, at 11:17 a.m. indicated: R46 had stated he'd been vomiting for the last two days and his emesis was now brown like stool. R46 had vomited three times in the ambulance enroute to the ER and the vomit was described as dark brown liquid running out of his mouth. R46's abdomen was very firm, with no bowel sounds and the abdomen was distended. R46 complained of abdominal pain but was unable to rate the pain. R46 had his stomach drained via a nasogastric tube for ten minutes with 1400 mL of fluid output after which R46 stated he felt much better. R46 was alert and "states we should do what ever we have to do. Is comfortable now."

The hospital discharge summary dated 10/5/15, indicated R46 had undergone abdominal surgery to correct the small bowel obstruction, and had developed subsequent cardiac and anticoagulation issues as well as post-operative ileus (disruption in normal bowel motility) after the surgery. The ileus resolved with the replacement of a nasogastric tube; however, comfort cares were initiated and R46 passed away on 10/5/15.

During interview on 12/29/15, at 3:07 p.m. the director of nursing (DON) verified she would have expected staff to contact the on-call doctor immediately with the urgent clinical issues, especially when the resident was vomiting BM-type material and not feeling better.

During interview on 12/29/15, at 3:32 p.m. the nursing home's health information coordinator/nursing scheduler (HIM) stated LPN-B was not well and was currently in a hospital intensive care unit, unavailable for interview. The HIM verified LPN-F had been a pool nursing staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 41	F 309		

During interview on 12/29/15, at 3:45 p.m. the acting administrator, who had been the DON at the time of the incident stated she'd thought R46's family had indicated he was admitted to the hospital with a bowel obstruction, but that it had later been found to be a narrowed bowel. The administrator was unable to recall specifics regarding R46's episode of illness; however, stated she would have expected staff to contact/call the on-call and/or primary physician directly with concerns that were urgent. The administrator stated she would have expected the staff to check the vital signs, bowel movement status, appetite and fever status while conducting a physical assessment. The administrator stated she thought LPN-A was a good nurse and trusted her judgment. She further verified LPN-A worked every Thursday night shift.

When LPN-A was interviewed about the incident on 12/29/15 at 4:02 p.m., LPN-A stated she'd received report from the evening nurse (LPN-F) on 9/25/15, regarding R46's emesis, but had been unaware a fax had been sent. LPN-A stated she'd worked with R46 at least one time prior and was aware R46's vomiting and complaints of not feeling well was new for R46. She was aware R46 had thrown up and had not been eating well, and had subsequently administered Maalox during the night. LPN-A thought the Maalox had helped somewhat the first time she administered it (around 2:00 a.m.). LPN-A verified R46 had emesis of what looked like stool but there was no odor. She verified his abdomen had also seemed a little distended. LPN-A was unaware whether R46 had complained of pain. LPN-A said R46 subsequently vomited and it looked more like BM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 42 later in her shift (around 5:00 a.m.) at which time she'd become concerned that he may have something wrong with his small bowel. LPN-A said she'd proceeded to fill out all the transfer paperwork for a hospital discharge; however, did not call the RN on call nor notify the physician of her concern. LPN-A indicated she had passed along the paperwork and her concern to the day nurse, LPN-B, who arrived on duty at 6:00 a.m. on 9/26/25. LPN-A stated she'd told LPN-B to do an assessment to follow up on R46's condition. During the interview, LPN-A stated she thought there had been a history of small bowel concerns she had noted when filling out the paperwork to pass along to the day shift personnel. During a follow up interview on 12/30/15, at 9:12 a.m. the administrator stated LPN-A should have notified the physician sooner about R46's symptoms, and that she had not been aware there had been a delay in his nursing care and physician notification of his condition. During interview on 12/30/15, at 2:11 p.m. the medical director was interviewed and stated she would have expected nursing staff to call when they filled out the paperwork to transfer R46 to the hospital. The medical director stated although R46 may have subsequently expired anyway, prompt medical care would have made him comfortable. The medical director stated the effect of delayed medical care/interventions related to R46's medical outcome was difficult to state since she was not his usual physician. During interview on 12/31/15, at 9:27 a.m. medical doctor (MD)-A (R46's usual physician) stated he would have expected staff to have called the clinic and/or the on-call physician when	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 309	Continued From page 43	F 309		

R46 began vomiting stool-like material. MD-A stated faxing medical staff at the clinic at 6:00 p.m. was inappropriate as the fax machine was not attended at that time of day. MD-A stated he'd been concerned about the potential for ischemic bowel when R46 arrived at the hospital, due to the delay in receipt of medical attention after his symptoms began. MD-A stated R46 had made some "depressed" comments prior to the hospital transfer on 9/26/15, but those comments were a "sidebar" and were not relevant to this issue. MD-A confirmed R46 would have been more comfortable if he had been examined sooner in the ER. MD-A stated, "when you are vomiting brown stuff, it is probably a good idea if you are seen."

The facility's policy entitled Change in Condition SBAR last revised 3/15, indicated immediate notification of the physician was required for any symptom, sign or apparent discomfort that was sudden in onset, a marked change (i.e. more severe) in relation to usual signs and symptoms and was unrelieved by measures already prescribed. The policy further indicated in a section related to abdominal distension that immediate notification of the physician was required when there was rapid onset, or presence of marked tenderness, fever, vomiting or GI (gastrointestinal) bleeding.
Review of R21's Medication Administration Record (MAR) dated December 2015, identified that blood sugar (BS) readings were monitored five (5) times per day. Between the dates of 12/1 - 12/29/15 there were 44 blood sugar (BS) levels which were documented as 400 milligrams (mg)/ deciliter (dL) and above, with 25 of those documented BS level readings higher than 430 mg/dL. Although the resident's blood sugars

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 309	Continued From page 44	F 309		

fluctuated dramatically, there had not been physician notification of blood sugars which registered greater than 430 mg/dL.

A physician's order, dated 11/3/15 indicated, Insulin Regular Human Solution 100 unit/milliliter (ml) Inject as per sliding scale with the final ordered dosage "greater than 400 mg/dL: give 6 units".

A physician's order, dated 12/7/15 indicated, Insulin Glargine Solution 100 unit/ml- 24 units subcutaneous (SQ) one time per day (QD), and sliding scale with Regular Humalog solution 100 unit/ml. BS readings were to be faxed to the diabetic educator weekly. No parameters were listed for notification of the physician regarding hypo (low) or hyper (high) glycemia (BS).

During interview on 12/30/15, at 3:10 p.m. a licensed practical nurse (LPN)-C indicated there were no protocols, or orders, indicating when to notify the medical doctor (MD) of BS levels. LPN-C stated she would notify the MD related to how the resident felt and if there was a high BS-which she identified as "way above 400's-500's".

On 12/30/15, at 2:36 p.m. LPN-D stated she would notify the MD if she obtained a BS result above 600 mg/dL. LPN-D confirmed on 12/29/15, the supper BS check for R21 was 521 mg/dL and the MD was not updated. LPN-D further stated R21 frequently has BS readings above 400 mg/dL and the facility standing orders read to give 6 units of regular insulin if the BS was greater than 350 mg/dL. LPN-D indicated when the glucometer read "high" it was the result of a BS over 600 mg/dL and she would telephone

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 45	F 309		

the nurse on call at the hospital to report the reading.

During interview on 12/30/15, at 2:57 p.m. the diabetic educator indicated she received weekly reports of R21's BS results. She further stated the clinic has a protocol for diabetic medication adjustments and this was what insulin changes were based upon. The diabetic educator further stated R21 had a history of being a brittle diabetic and nursing staff were supposed to call the medical provider on call and/or the triage nurse related to changes in status. The diabetic educator further indicated she thought BS parameters had been identified when R21 was recently discharged from the the hospital on 12/5/15. She indicated the parameters would have been determined by the discharging MD.

During interview on 12/30/15, at 3:12 p.m. RN-B and RN-C stated there were facility parameters for reporting BS readings. They referenced the documentation on the facility's standing orders and stated that would be the practice they followed unless individualized orders were written. RN-B indicated if a resident was symptomatic she would notify the physician based on the standing order instructions. RN -B and RN-C indicated they were not aware of the Change in Condition policy related to immediate reporting of BS readings above 430 mg/DL. RN-B stated, "we will have to make certain everyone is aware of this policy".

During interview on 12/31/15, at 8:36 a.m. LPN-E indicated she had been employed as an LPN for 3 months at the facility and had received training on BS checks which included: to test in a private area, wear gloves, and follow MD orders if the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 46	F 309		

resident had orders for a sliding scale (SS), or a specific insulin order. LPN-E stated if there was a "high" reading she would contact the MD on call for direction. In the instance of a 400+ reading for R21 LPN-E indicated she would administer the ordered SS dose and recheck in one hour and then recheck in the following hour to determine whether the BS was responding to insulin. LPN-E stated she would probably not notify the MD in this instance as this resident has a history of BS fluctuations. LPN-E further indicated R21 did not have specific orders for follow up but this is what she would do.

On 12/31/15, at 9:04 a.m. R21's physician, also the facility's medical director, stated typically a resident would have a specific order that comes from the hospital for sliding scale insulin. R21's physician stated R21 had been her patient even before admission to the nursing home, and had a history of blood sugars fluctuating "all over" but that the resident was usually most comfortable when her blood sugars ran over 300 mg/dl. However, stated if she'd received a telephone call for an elevated blood sugar level she could provide specific orders as to when staff were required to recheck the BS and call back the results. She stated, "they call if the meter reads 'hi' because they have nothing to base it off. If the blood sugar is below 70 mg/dL staff would need to initiate the hypoglycemia protocol." She further indicated she would expect staff to notify the clinic and/or on-call staff to update on BS readings that were outside range.

When interviewed on 12/31/15, at 1:00 p.m. the director of nursing (DON) reviewed the December 2015 documentation of R21's BS readings and indicated she was unaware of the wide fluctuation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 47	F 309		

of BS readings for R21 which were over 430 mg/dL. She confirmed she would have expected staff to notify the attending MD and/or the on-call staff in accordance with the Change in Condition When to Report to the MD/NP/PA policy.

The facility's policy related to physician notification for blood sugar fluctuations, entitled, Change in Condition When to Report to the MD/nurse practitioner(NP)/physician assistant last revised 3/15, included: "blood sugars greater than 430 mg/dL (or machine registers high) in diabetic patients using sliding scale insulin should be immediately reported to the physician or nurse practitioner (NP)."
When interviewed on 12/29/15, at approximately 8:50 a.m. the DON confirmed R6 was unable to understand or be understood, and staff communicated using gestures and facial expressions.

The facility diagnostic report indicated R6 was admitted to the facility in 2014, with diagnoses including dementia without behavioral disturbance with a cognitive communication deficit.

R6's annual MDS assessment dated 10/9/15, revealed the resident had severely impaired cognition with daily wandering that significantly intruded on the privacy of others, physical behavior towards others 1-3 days, other behavior not directed towards others 4-6 days but less than daily. The MDS also indicated R6 required extensive assistance with bed mobility, transfer, locomotion on/off unit, dressing, toilet use, and personal hygiene. The MDS further indicated neither the resident nor family/significant other was able to complete the daily and activity preference portion of the assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309		F 309		

Continued From page 48

R6's care plan dated 10/12/15, indicated a risk for falls related to (r/t) history of falls, generalized weakness, gait/balance problems, bladder incontinence, hearing and vision impairments, impaired cognition, and difficulty communicating needs. Interventions included: anticipate and meet needs, encourage activities that promoted exercise, physical activity for strengthening and improved mobility, ambulate with staff in hallway three times daily, redirect when wheeling close to wall or objects, use distraction when restless. The care plan further identified a communication problem r/t hearing deficit and head injury. Interventions included: discuss with resident/family concerns or feelings regarding communication difficulty, family reported that they were unable to communicate with resident due to the progression of his dementia, observe effectiveness of communications strategies and assistive devices.

On 12/29/15, R6 was continuously observed from 1:16 to 4:17 p.m.:
- At 1:16 p.m. R6 was observed being ambulated by two staff with a third pushing the resident's wheelchair (w/c) behind him down the west "Cityside" hallway. The resident was cooperative while walking and although could not be understood, spoke and smiled to the staff, who in turn talked to the resident. After walking the length of the hall, the resident was assisted back to the dayroom in front of the television (TV). R6 then propelled himself throughout the dayroom in his w/c.

-At 1:27 p.m. NA-A brought R6 a sensory item that was rounded in shape and consisted of multiple-colored hollow tubes held together with a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309		F 309		

Continued From page 49

-type cord enabling the object to be stretched and manipulated. R6 accepted the item, talking out loud constantly and NA- walked away. R6 held the item but did not appear interested, nor did he attempted to manipulate the object.

-At 1:34 p.m. a staff member transported R6 from the middle of the dayroom to a table with another resident. R6 continued to verbalize while the sensory object remained in his lap. No interaction with staff and R6 was observed. R6 remained at the table for a short time and then began to propel himself in w/c around the dayroom.

-At 1:44 p.m. R6 started to propel behind the nurses' station. LPN-C redirected the resident away from the area and then assisted him to his room.

-At 1:52 p.m. R6 propelled himself out of his room to the drinking fountain in the west hallway. R6 had a plastic mug and was attempting to obtain water from the fountain. A staff member approached R6 and assisted him with filling the mug with water then replaced the cover on the mug. R6 accepted the water mug then continued to mumble out loud and propel himself down the west hallway towards the administrative offices. Once R6 made it to the end of the hallway, staff intercepted the resident and returned him to his room.

-At 2:00 p.m., R6 was lying in bed on top of covers without shoes. A sensory item the resident was holding earlier was on the resident's legs. R6 eyes were wide open.

-At 2:07 p.m. R6 was sitting up on the edge of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 50	F 309		

bed with feet dangling, and the sensory item was on his lap. The resident was not touching or paying attention to the sensory object.

- At 2:30 p.m. R6 was seated on the edge of his bed. His left shoe was off his foot, as he held his other shoe and pulled out the laces.

-At 2:39 p.m., R6 continued to sit on the edge of bed in room attempting to pull the laces out of his left shoe. Coffee social and word games activity was being conducted in the dining room at that time. At 2:56 p.m. R6 continued to sit on edge of bed having successfully removed the laces from his shoe. At 3:10 p.m. NA-C entered R6's room and greet him. A trained medication aide (TMA)-A entered the room and asked if the resident was still "working on his shoe." NA-C asked if R6 was supposed to have the shoe. TMA-A responded that if she could get it laced and on the resident, then they could put him in his chair and not worry about it. On 12/29/15, at 3:57 p.m. R6 seated on side of bed examining the unlaced shoe. A wellness group was scheduled to begin at 4:00 p.m. On 12/29/15, at 4:17 p.m. R6 was still on the edge of the bed, attempting to re-lace his shoe. This activity had been continuous since 2:30 p.m. or nearly two hours.

R6 was not approached and/or involved in any significant staff to resident communication during the three hour continuous observation on 12/29/15. The resident was handed a sensory object though staff failed to model how object could be used or spend time with the resident. Staff provided minimal interaction with R6 and continually redirected him to his bedroom and eventually put into bed though the resident was wide awake.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ________ B. WING ________	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 51	F 309		

R6 was observed on 12/30/15, during the following times:
- At 7:50 a.m. R6 was seated alone at a table in the corner of the dining room eating breakfast independently. The table was pushed flush to the wall on two sides. R6's back was to the other residents as he faced the wall.

- At 7:58 a.m. R6 was assisted in the w/c by staff to the Cityside dayroom and was situated at a table. Staff handed R6 a multicolored cylinder shaped sensory object that also made sound when manipulated. Staff then left the area without further interaction. R6 placed the object behind him on the seat of his w/c and proceeded to propel himself past the nurses' station towards the dining room to the medication cart where LPN-C was standing. Although R6 could not be understood, he vocalized loudly. LPN-C informed R6 he had already eaten and assisted the resident back to his room. LPN-C left the resident's room at 8:05 a.m. R6 was lying on the bare mattress and pillow without a pillowcase. The bedding was piled at the end of the bed. R6 was holding onto the grab bar, attempting to sit up in bed.

-At 8:25 a.m. R6 was seated at the edge of the bed and the w/c was positioned next to bed with the brakes locked. R6's tennis shoes were located on the seat of the w/c. At 8:36 a.m. R6 was wearing shoes, and was ambulating along the side of the room as he felt the wall. The surveyor alerted the administrator who was walking by to question whether R6 was capable of independent ambulation. The administrator stated R6 did sometimes ambulate, and redirected R6 to his wheelchair. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 52	F 309		

administrator asked R6 whether he needed his oxygen (O2) as he was heavily breathing. The O2 was applied via a nasal cannula and the administrator left the room.

- At 8:49 a.m. R6 removed the 02 tubing, propelled himself from the room via the w/c and entered another resident's room located across the hall. Upon entering the doorway, housekeeping (Hspkg)-A intervened and redirected R6 back to his own room.

-At 10:04 a.m. a church activity was conducted in the activity room. R6 independently propelled himself down the west hallway but once he turned the corner, the administrator redirected and propelled him back down the direction of the hallway. R6 then entered the dayroom, propelling himself around the perimeter of the area, pausing to look out the window and watched the fish in the fish tank. R6 propelled himself toward the direction of the east hallway and remained seated here until 10:30 a.m. LPN-C then moved R6 from the east hallway to a table located in the dayroom. No verbal communication nor interaction was noted between staff and R6.

-At 11:07 a.m. R6 was seated in w/c in dayroom by nurses station. A wellness activity in process and was identified on the plan of care as an planned intervention. At 11:27 a.m. R6 was seated in w/c in Cityside dayroom near nurses station when the activity director (AD) entered the dayroom, said "Hi" to R6, turned up the volume on the TV and walked away. At 11:48 a.m. R6 remained seated at the table in the corner of the dining room with his back away from the other residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING _______ B. WING _______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 309	Continued From page 53	F 309		

-At 2:16 p.m. NA-B and NA-A attempted to assist R6 to ambulate, however, the resident did not stand when prompted for approximately 30 seconds. The transfer belt was removed and the staff left the resident.

-At 2:35 p.m. R6 was in the dining room where the men's group activity was held in the main area of the dining room. R6 was served a snack while located in the front area of the main dining room, partitioned off by a wall with two openings. R6 was offered his snack at the table where he routinely had been served meals, alone and away from the other residents who were served their snacks in the main dining area. At 2:41 p.m. when R6 finished his snack, propelled himself around the front area of the dining room near his designated table. No staff interacted with R6 until he was assisted out of the dining room towards the direction of his room at 2:44 p.m. When interviewed on 12/30/15, at 12:41 p.m. the AD cited a communication barrier.

When interviewed on 12/20/15, at 3:36 p.m. TMA-A indicated they were unable to communicate with the resident and had not attempted any alternative method, and said it was unfair to R6. TMA-A said R6's family visited approximately monthly.

When interviewed on 12/31/15, at 8:50 a.m. the licensed social worker (LSW) and DON stated they were unsure whether R6 would have been able to talk to his family on the telephone. Although they had never attempted to assist him to contact his family, they said it would be worth attempting.

When interviewed on 12/31/15, at 1:25 p.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 309	Continued From page 54 DON confirmed the R6 should not have been returned to his room or put into bed when he wandered. The DON stated, "That's sad" when informed the resident had been put into bed with a bare mattress, linen pushed to the end of the bed, and no pillowcase on the pillow. The DON agreed staffs' interventions and/or lack of appropriate interventions were concerning.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were implemented to prevent significant weight loss for 1 of 3 residents (R28) reviewed for nutritional status. Findings include: R28's physician order sheet dated 7/1/15, revealed diagnoses including stroke, chronic kidney disease and dementia.	F 325	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:	2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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 325

Continued From page 55

The quarterly Minimum Data Set (MDS), dated 12/11/15 revealed R28 had a weight loss of 5% in the past month or 10% in the past 6 months. The residents current weight at 150#. No chewing or eating problems. The MDS further identified R28 had experienced a weight loss of 20# pound (lb) from the previous MDS dated 9/16/15, of a significant change.

Review of the most current care plan identified R28 as having potential nutritional problems due to dementia and decreased cognition. Interventions listed include: staff assist to set up residents meals, monitor the residents intake and report any changes to the physician, monitor the residents weights and report to the physician any significant weight loss and allow the resident time to eat in a calm setting.

Review of R28's log of weights revealed a 20 lb loss from 170 to 150 lbs. between 9/15 and 12/15 (3 month period).

Review of R28 nutritional assessment dated 10/14/15 indicates the residents weight was at 170#. The resident eats an average 75-100% of his meals and is on a regular diet with no chewing or swallowing problems.

Review of R28's mini nutritional assessment dated 12/14/15, with a significant change indicates the residents food intakes are stable and has not declined. The resident is showing a weight loss of 20# in the past 3 months and is at risk for malnutrition. No other information was documented related to causal factors nor interventions related to the weight loss.

Review of R28's dietary intakes for the previous 3

F 325

1. Resident #28 had his diet reviewed by a licensed dietician and changes made according to his clinical needs.
2. Residents showing weight loss (all residents were reviewed for weight loss) had their dietary needs reviewed by a licensed dietician and any changes made that were necessary to improve their clinical profile with regard to nutrition.
3. Education will be completed on 2-5-16 at an all staff meeting to ensure that interventions are implemented to prevent significant weight loss.
4. The Interdisciplinary Team will meet weekly to review and discuss weight loss and interventions for nutritional services. The dietary manager will document new interventions for nutritional concerns. The MDS Coordinator will do an audit weekly for 2 months to ensure that the nutritional concerns of residents are being followed.
5. The data collected will be reviewed/discussed at the quarterly QA&A meeting. At this time the QA&A committee will make the decision/recommendation regarding any follow-up studies.

The Dietary Manager and MDS Coordinator will be responsible for this POC.
Completion Date: 2-8-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 325	Continued From page 56	F 325		

months revealed intakes ranging from 0-100% at meals. Average daily intake of food is 25-50%. The residents food intake log revealed the resident had an increased decline in eating for the months of 11/15 and 12/15.

R28's most current dietary progress note, completed by the dietician on 12/15/15, indicated the resident's significant weigh loss may be related to the residents increased dementia and requiring more assistance with setting up his meals. No recommendations were provided.

During interview with the dietary director (DD) on 12/29/15 at 2:00 p.m., indicated she was unsure of who was responsible for monitoring R28's weights, but confirmed she had completed the most current MDS assessment which triggered/identified R28's significant weight loss. The DD stated R28's weight loss had been discussed with the registered dietician (RD) on 12/15/15, but the RD did not provide any recommendations.

During observations of R28 eating breakfast on 12/30/15, at 8:00 a.m. staff were feeding the resident his meal. The resident consumed 90% of his meal but did not participate in the process. The resident received a regular mechanical soft diet with no chewing or swallowing problems.

During interview with the facility RD on 12/30/15, at 8:00 a.m. she confirmed she was aware of R28's significant weight loss and stated the nursing staff indicated R28's weight loss was probably due to his dementia and he required more assistance with eating. The RD further included she did not recommend any type of intervention nor recommendation for R28's weight

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 325	Continued From page 57 loss due to the residents body mass index (BMI) being within normal ranges. The RD further stated she was not concerned about a residents weight loss if they fall within their BMI, but may follow up the following month. When further questioned, the RD did confirm R28's significant weight loss should have been addressed by the staff for causal factors and follow up interventions.	F 325		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure 1 of 5 rooms (Room 109, R6) reviewed with floor or wall damage had bathroom sheet rock that was maintained in good repair. Findings include: During observation of bathroom in room 109 (R6) on 12/31/15, at 8:30 a.m. it was noted to have a hole approximately 15 inches by 4 inches in the sheetrock at the base of the bathroom wall which is adjacent to the tub room. During observation and interview on 12/31/2015, at 8:35 a.m. the maintenance director confirmed the damaged wall in the bathroom of room 109. He stated, "tub has been leaking and this has damaged the resident's wall". He indicated the	F 465	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1. Resident #6 bathroom wall was repaired by maintenance. 2. All resident s rooms were observed for damage to walls and repairs made as needed. 3. Education was completed at an all	2/8/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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 465	Continued From page 58 tub room was adjacent to R6's bathroom. The maintenance director further confirmed a quarter size hole in the wall below the toilet paper dispenser and agreed the areas in the bathroom did not create a homelike environment. The maintenance director could not provide a policy/procedure but indicated staff would fill out a request on the clipboard when there was a problem to be fixed.	F 465	staff meeting on 2-5-16. Staff were informed to notify the maintenance director immediately when they see things that are damaged and need repair and maintenance was in-serviced on the need to provide repairs for the aesthetic enjoyment of the residents. 4. The Maintenance director will do a weekly walk through checking for damage in rooms for 1 month and then bi-monthly for 2 months and then monthly to ensure that the facility does not have any walls in need of repair. 5. The data collected will be reviewed/discussed at the quarterly QA&A meeting. At this time the QA&A committee will make the decision/recommendation regarding any follow-up studies. The Maintenance Director and Administrator will be responsible for this POC. Completion Date: 2-8-16	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5378026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**12/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 29, 2015. At the time of this survey, Valley View Manor was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/29/2016

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**12/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Valley View Manor was constructed as follows: The original building was constructed in 1972, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 1st Addition was constructed in 1976, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction; The 2nd Addition was constructed in 1989, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 3rd Addition was constructed in 1999, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(000) construction. The nursing home is separated from an assisted living facility by a 2-hour fire wall assembly, with an opening protective consisting of a labeled, 90-minute self-closing, positive latching fire door	K 000		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245378	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING	(X3) DATE SURVEY COMPLETED **12/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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
K 000	Continued From page 2 assembly. The facility has a fire alarm system with smoke detection at all smoke barrier doors. The 1999 addition has a full corridor smoke detection system. The entire system is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 40 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain smoke barrier wall in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, 8.3.2 and 8.3.6. The deficient practice could affect 12 out of 40 residents. Findings include:	K 025	1. Maintenance caulked with fire barrier caulk the penetration breach in the southwest hallway and checked the other smoke barriers for possible breach. 2. The completion date was 1-4-16. 3. The Maintenance Director is	1/4/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**12/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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
K 025	Continued From page 3 On facility tour between 11:00 AM and 1:00 PM on 12/29/2015, observation revealed that the smoke barrier in the Southwest Hallway has an open penetration around cables above smoke barrier doors above the lay in ceiling. NOTE: All smoke barriers need to be checked from exterior wall to exterior wall. This deficient practice was confirmed by the Facility Maintenance Director (RP) at the time of discovery.	K 025	responsible for this POC and monitoring to ensure that this deficiency does not reoccur.	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2.1 and 7.2.1.5.4, 7.2.1.6.1(d) and the 2007 MN State Fire Code, Appendix I. The deficient practice could affect 20 out of 40 residents. Findings include: On facility tour between 11:00 AM and 1:00 PM on 12/29/2015 , observation revealed that the Emergency East Exit did not function properly.	K 038	1. Maintenance replaced the MAG lock board to the East exit door on 1-8-16. The Maintenance Director will check the doors for proper functioning weekly x 1 month and then monthly. 2. The completion date was 1-8-16. 3. The Maintenance Director is responsible for this POC to ensure that exits are readily accessible at all times.	1/8/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**12/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE** **LAMBERTON, MN 56152**

(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
K 038	Continued From page 4 Magnetic lock did not disengage after pushing on door handle for 30 seconds. System was disengaged so that the door could be opened under all circumstances. This deficient practice was confirmed by the facility Maintenance Director (RP) at the time of discovery.	K 038		

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
January 20, 2016

Ms. Dawn Giese, Administrator
Valley View Manor Hcc
200 East Ninth Avenue
Lamberton, MN 56152

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5378029

Dear Ms. Giese:

The above facility was surveyed on December 28, 2015 through December 31, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 <u>only a suggestion</u> 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 contact Kathy Serie at (507) 476-4233.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
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 December 28, 29, 30, and 31 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring,	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 000	Continued From page 1 Licensing and Certification Program; 12 Civic Center Plaza, Suite 2105, Mankato, Minnesota 56001.	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an	2 265		2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 265	Continued From page 2	2 265		

attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:

A. an accident involving the resident which results in injury and has the potential for requiring physician intervention;

B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;

C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;

D. a decision to transfer or discharge the resident from the nursing home; or

E. expected and unexpected resident deaths.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to notify the physician in a timely manner for 2 of 4 residents (R46, R21) reviewed for hospitalization who experienced significant changes in condition requiring medical treatment. This resulted in actual harm for R46, who experienced prolonged discomfort, dehydration and vomiting, related to delayed physician notification and subsequent transfer to an inpatient facility for a small bowel obstruction.

Completion Date: 2-8-16

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ____ B. WING ____	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 265	Continued From page 3	2 265		

R46's discharge orders to the nursing home dated 9/17/15, identified a discharge condition of improving with orders for physical and occupational therapy.

R46's physician's progress notes, dated 9/18/15 indicated diagnoses of spinal stenosis of the lumbar region, sepsis, and urinary tract infection. The physician's progress note also identified a history of diverticulitis of the colon.

R46's admission Minimum Data Set (MDS), dated 9/24/15 identified a Brief Interview for Mental Status score of 13/15 (cognitively intact). No care area assessments were completed with the MDS.

R46's care plan, dated 9/30/15 identified no cognitive impairments and that R46 desired to return to the community.

R46's September 2015 medication sheets revealed R46 had received Maalox (an antacid) 30 cubic centimeters (cc)'s on 9/25/15 a total of four times on that date, as well as one dose at 2:00 a.m. on 9/26/15. Notations documented by licensed practical nurse (LPN)-A, on the back of the medication administration record for a dose administered on 9/25/15, at 2:00 a.m. indicated the medication had been given for stomach upset since supper. No follow up assessment for effectiveness was completed. A subsequent entry dated 9/26/15, at 2:00 am. indicated R46 had received another dose of Maalox for an upset stomach and emesis; the follow up result was listed as had another emesis at 4 a.m. None of the other doses administered had follow up results documented.

A nursing progress note written by LPN-F on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 265	Continued From page 4	2 265		

9/25/15 at 8:30 a.m., indicated R46 had hiccups and complaints of not feeling well. The notes indicated R46 had been given Maalox 30 cc's along with Thorazine and had begun retching after his morning medications. In addition, R46 had experienced a large projectile emesis all over the bed and himself, and had refused to eat anything for breakfast, stating he had consumed orange juice that had all come up.

A nursing progress note documented by LPN-F on 9/25/15, at 1:39 p.m. indicated R46 had a large emesis, and that the resident had stated he was not feeling well. The notes indicated his hiccups had subsided for a while but had then started again. Documentation indicated R46 had received Maalox and Thorazine (an antipsychotic medication used for antiemetic properties) with another small emesis afterward. The emesis was documented as having had food particles present and was described as having a colicky odor. R46's temperature was documented as having been elevated at 99.0 degrees Fahrenheit (F).

A nursing progress note dated 9/25/15, at 6:00 p.m. per LPN-F indicated R46 had stayed in bed most of the evening. The note indicated R46's hiccups were better over the early evening hours but that R46 had been stated his tummy still didn't feel right and that whenever he moved he began to gag. R46 had eaten Jell-O for supper and had sips of water. Additionally, the documentation indicated a fax (facsimile) had been sent to medical doctor (MD)-A with an update on R46's condition including that R46 had an elevated temperature at 99.5 degrees F and complained of feeling chilly.

A nursing progress note dated 9/25/15, at 11:05 p.m. per LPN-F indicated R46 had not been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 265	Continued From page 5	2 265		

feeling well, and had been having brown colored emesis twice on the afternoon shift which did not appear to have a feces odor. Maalox 30 cc's had been given to help with hiccups and R46's vitamins had been held due to emesis.

A nursing progress note by LPN-A, dated 9/26/15, at 1:56 a.m. indicated R46's abdomen was distended, his bowel sounds were difficult to hear and he had been having emesis which looked like BM. R46's temp was noted to be slightly elevated at 99.1 degrees F.

A nursing progress note written by LPN-A on 9/26/15, at 4:48 a.m. indicated R46 had 100 cc's of emesis, like soft formed/loose BM (bowel movement) with no odor. The note further indicated R46 was cool and clammy, with a slightly elevated temperature at 99.1 degrees F. R46 had a wastebasket beside him, and continued to wretch.

A nursing progress note entered by LPN-B, dated 9/26/15, at 9:57 a.m. indicated R46 had two further emesis of greenish liquid thick with pieces of BM looking in it. In addition, the note indicated an acute care hospital had been called and an order was received to transfer R46 to their emergency room (ER) via ambulance. The note indicated R46's daughter was updated and had agreed to meet him at the hospital. R46 left the facility at 8:45 a.m.

A faxed physician's order dated 9/26/15 was present in R46's record and verified the physician order to transfer per ambulance to the acute care hospital.

An additional nursing progress note dated 9/26/15, at 2:06 p.m. indicated R46 had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER: **VALLEY VIEW MANOR HCC**

STREET ADDRESS, CITY, STATE, ZIP CODE: **200 EAST NINTH AVENUE, LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 265	Continued From page 6	2 265		

admitted to the acute care hospital with a diagnoses of bowel obstruction, and would need surgery.

A faxed physician's order sent on 9/25/15, at 6:05 p.m. from the facility to R46's primary physician identified that R46 had emesis since 8:30 a.m., experienced several rounds of hiccups throughout the day and had been unable to eat or drink. R46 complained of feeling weak. The fax had not been signed off until on 9/28/15, three days later, when the nurse practitioner (NP)-A responded with a statement including, "Noting telephone order to transfer to ER on 9/26/15. Please do NOT fax in regard to situations that need attn [attention] that day. This will be sent to [physician] - today 9/28/15. Please review the faxing for response procedure. Thx [Thanks]."

The ER progress note dated 9/26/15, at 10:36 a.m. was reviewed. The ER note indicated R46 had appeared distressed when examined, had been uncomfortable, and had dry oral mucous with dried brown material on the tongue and lips. The ER note further indicated R46's abdomen was firm and diffusely distended, mildly tender with no appreciable bowel sounds. In addition, 1800 milliliters (ml) of brown liquid had been drained from R46's stomach after the insertion of a nasogastric tube. R46 had received 2000 ml of normal saline intravenous for hydration. The ER physician's note indicated R46 had appeared quite dehydrated and verified the admitting diagnoses of small bowel obstruction and severe dehydration.

The ER registered nurse's assessment dated 9/26/15, at 11:17 a.m. indicated: R46 had stated he'd been vomiting for the last two days and his emesis was now brown like stool. R46 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 265	Continued From page 7	2 265		

vomited three times in the ambulance enroute to the ER and the vomit was described as dark brown liquid running out of his mouth. R46's abdomen was very firm, with no bowel sounds and the abdomen was distended. R46 complained of abdominal pain but was unable to rate the pain. R46 had his stomach drained via a nasogastric tube for ten minutes with 1400 mL of fluid output after which R46 stated he felt much better. R46 was alert and "states we should do what ever we have to do. Is comfortable now."

The hospital discharge summary dated 10/5/15, indicated R46 had undergone abdominal surgery to correct the small bowel obstruction, and had developed subsequent cardiac and anticoagulation issues as well as post-operative ileus (disruption in normal bowel motility) after the surgery. The ileus resolved with the replacement of a nasogastric tube; however, comfort cares were initiated and R46 passed away on 10/5/15.

During interview on 12/29/15, at 3:07 p.m. the director of nursing (DON) verified she would have expected staff to contact the on-call doctor immediately with the urgent clinical issues, especially when the resident was vomiting BM-type material and not feeling better.

During interview on 12/29/15, at 3:32 p.m. the nursing home's health information coordinator/nursing scheduler (HIM) stated LPN-B was not well and was currently in a hospital intensive care unit, unavailable for interview. The HIM verified LPN-F had been a pool nursing staff.

During interview on 12/29/15, at 3:45 p.m. the acting administrator, who had been the DON at the time of the incident stated she'd thought

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 265	Continued From page 8 R46's family had indicated he was admitted to the hospital with a bowel obstruction, but that it had later been found to be a narrowed bowel. The administrator was unable to recall specifics regarding R46's episode of illness; however, stated she would have expected staff to contact/call the on-call and/or primary physician directly with concerns that were urgent. The administrator stated she would have expected the staff to check the vital signs, bowel movement status, appetite and fever status while conducting a physical assessment. The administrator stated she thought LPN-A was a good nurse and trusted her judgment. She further verified LPN-A worked every Thursday night shift. When LPN-A was interviewed about the incident on 12/29/15 at 4:02 p.m., LPN-A stated she'd received report from the evening nurse (LPN-F) on 9/25/15, regarding R46's emesis, but had been unaware a fax had been sent. LPN-A stated she'd worked with R46 at least one time prior and was aware R46's vomiting and complaints of not feeling well was new for R46. She was aware R46 had thrown up and had not been eating well, and had subsequently administered Maalox during the night. LPN-A thought the Maalox had helped somewhat the first time she administered it (around 2:00 a.m.). LPN-A verified R46 had emesis of what looked like stool but there was no odor. She verified his abdomen had also seemed a little distended. LPN-A was unaware whether R46 had complained of pain. LPN-A said R46 subsequently vomited and it looked more like BM later in her shift (around 5:00 a.m.) at which time she'd become concerned that he may have something wrong with his small bowel. LPN-A said she'd proceeded to fill out all the transfer paperwork for a hospital discharge; however, did	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 265	Continued From page 9	2 265		

not call the RN on call nor notify the physician of her concern. LPN-A indicated she had passed along the paperwork and her concern to the day nurse, LPN-B, who arrived on duty at 6:00 a.m. on 9/26/25. LPN-A stated she'd told LPN-B to do an assessment to follow up on R46's condition. During the interview, LPN-A stated she thought there had been a history of small bowel concerns she had noted when filling out the paperwork to pass along to the day shift personnel.

During a follow up interview on 12/30/15, at 9:12 a.m. the administrator stated LPN-A should have notified the physician sooner about R46's symptoms, and that she had not been aware there had been a delay in his nursing care and physician notification of his condition.

During interview on 12/30/15, at 2:11 p.m. the medical director was interviewed and stated she would have expected nursing staff to call when they filled out the paperwork to transfer R46 to the hospital. The medical director stated although R46 may have subsequently expired anyway, prompt medical care would have made him comfortable. The medical director stated the effect of delayed medical care/interventions related to R46's medical outcome was difficult to state since she was not his usual physician.

During interview on 12/31/15, at 9:27 a.m. medical doctor (MD)-A (R46's usual physician) stated he would have expected staff to have called the clinic and/or the on-call physician when R46 began vomiting stool-like material. MD-A stated faxing medical staff at the clinic at 6:00 p.m. was inappropriate as the fax machine was not attended at that time of day. MD-A stated he'd been concerned about the potential for ischemic bowel when R46 arrived at the hospital,

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 265		2 265		

Continued From page 10

due to the delay in receipt of medical attention after his symptoms began. MD-A stated R46 had made some "depressed" comments prior to the hospital transfer on 9/26/15, but those comments were a "sidebar" and were not relevant to this issue. MD-A confirmed R46 would have been more comfortable if he had been examined sooner in the ER. MD-A stated, "when you are vomiting brown stuff, it is probably a good idea if you are seen."

The facility's policy entitled Change in Condition SBAR last revised 3/15, indicated immediate notification of the physician was required for any symptom, sign or apparent discomfort that was sudden in onset, a marked change (i.e. more severe) in relation to usual signs and symptoms and was unrelieved by measures already prescribed. The policy further indicated in a section related to abdominal distension that immediate notification of the physician was required when there was rapid onset, or presence of marked tenderness, fever, vomiting or GI (gastrointestinal) bleeding.

Review of R21's Medication Administration Record (MAR) dated December 2015, identified that blood sugar (BS) readings were monitored five (5) times per day. Between the dates of 12/1 - 12/29/15 there were 44 blood sugar (BS) levels which were documented as 400 milligrams (mg)/ deciliter (dL) and above, with 25 of those documented BS level readings higher than 430 mg/dL. Although the resident's blood sugars fluctuated dramatically, there had not been physician notification of blood sugars which registered greater than 430 mg/dL.

A physician's order, dated 11/3/15 indicated, Insulin Regular Human Solution 100 unit/milliliter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 265	Continued From page 11	2 265		

(ml) Inject as per sliding scale with the final ordered dosage "greater than 400 mg/dL: give 6 units".

A physician's order, dated 12/7/15 indicated, Insulin Glargine Solution 100 unit/ml- 24 units subcutaneous (SQ) one time per day (QD), and sliding scale with Regular Humalog solution 100 unit/ml. BS readings were to be faxed to the diabetic educator weekly. No parameters were listed for notification of the physician regarding hypo (low) or hyper (high) glycemia (BS).

During interview on 12/30/15, at 3:10 p.m. a licensed practical nurse (LPN)-C indicated there were no protocols, or orders, indicating when to notify the medical doctor (MD) of BS levels. LPN-C stated she would notify the MD related to how the resident felt and if there was a high BS-which she identified as "way above 400's-500's".

On 12/30/15, at 2:36 p.m. LPN-D stated she would notify the MD if she obtained a BS result above 600 mg/dL. LPN-D confirmed on 12/29/15, the supper BS check for R21 was 521 mg/dL and the MD was not updated. LPN-D further stated R21 frequently has BS readings above 400 mg/dL and the facility standing orders read to give 6 units of regular insulin if the BS was greater than 350 mg/dL. LPN-D indicated when the glucometer read "high" it was the result of a BS over 600 mg/dL and she would telephone the nurse on call at the hospital to report the reading.

During interview on 12/30/15, at 2:57 p.m. the diabetic educator indicated she received weekly reports of R21's BS results. She further stated the clinic has a protocol for diabetic medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 265	Continued From page 12	2 265		

adjustments and this was what insulin changes were based upon. The diabetic educator further stated R21 had a history of being a brittle diabetic and nursing staff were supposed to call the medical provider on call and/or the triage nurse related to changes in status. The diabetic educator further indicated she thought BS parameters had been identified when R21 was recently discharged from the the hospital on 12/5/15. She indicated the parameters would have been determined by the discharging MD.

During interview on 12/30/15, at 3:12 p.m. RN-B and RN-C stated there were facility parameters for reporting BS readings. They referenced the documentation on the facility's standing orders and stated that would be the practice they followed unless individualized orders were written. RN-B indicated if a resident was symptomatic she would notify the physician based on the standing order instructions. RN -B and RN-C indicated they were not aware of the Change in Condition policy related to immediate reporting of BS readings above 430 mg/DL. RN-B stated, "we will have to make certain everyone is aware of this policy".

During interview on 12/31/15, at 8:36 a.m. LPN-E indicated she had been employed as an LPN for 3 months at the facility and had received training on BS checks which included: to test in a private area, wear gloves, and follow MD orders if the resident had orders for a sliding scale (SS), or a specific insulin order. LPN-E stated if there was a "high" reading she would contact the MD on call for direction. In the instance of a 400+ reading for R21 LPN-E indicated she would administer the ordered SS dose and recheck in one hour and then recheck in the following hour to determine whether the BS was responding to insulin. LPN-E

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 265	Continued From page 13	2 265		

stated she would probably not notify the MD in this instance as this resident has a history of BS fluctuations. LPN-E further indicated R21 did not have specific orders for follow up but this is what she would do.

On 12/31/15, at 9:04 a.m. R21's physician, also the facility's medical director, stated typically a resident would have a specific order that comes from the hospital for sliding scale insulin. R21's physician stated R21 had been her patient even before admission to the nursing home, and had a history of blood sugars fluctuating "all over" but that the resident was usually most comfortable when her blood sugars ran over 300 mg/dl. However, stated if she'd received a telephone call for an elevated blood sugar level she could provide specific orders as to when staff were required to recheck the BS and call back the results. She stated, "they call if the meter reads 'hi' because they have nothing to base it off. If the blood sugar is below 70 mg/dL staff would need to initiate the hypoglycemia protocol." She further indicated she would expect staff to notify the clinic and/or on-call staff to update on BS readings that were outside range.

When interviewed on 12/31/15, at 1:00 p.m. the director of nursing (DON) reviewed the December 2015 documentation of R21's BS readings and indicated she was unaware of the wide fluctuation of BS readings for R21 which were over 430 mg/dL. She confirmed she would have expected staff to notify the attending MD and/or the on-call staff in accordance with the Change in Condition When to Report to the MD/NP/PA policy.

The facility's policy related to physician notification for blood sugar fluctuations, entitled, Change in Condition When to Report to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 265	Continued From page 14 MD/nurse practitioner(NP)/physician assistant last revised 3/15, included: "blood sugars greater than 430 mg/dL (or machine registers high) in diabetic patients using sliding scale insulin should be immediately reported to the physician or nurse practitioner (NP)." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility notifies the physician in a timely manner when the resident's condition changes and according to individualized needs. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance and review findings at the quarterly QA&A meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include:	2 302		2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 302	Continued From page 15	2 302		

(1) an explanation of Alzheimer's disease and related disorders;
(2) assistance with activities of daily living;
(3) problem solving with challenging behaviors; and
(4) communication skills.
(c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.
(d) The facility shall document compliance with this section.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to provide to residents and/or interested family members information regarding: Alzheimer's training staff received, who received training, how often, and a description of the training provided. This had the potential to affect all current residents of the facility and their families.

Completion Date: 2-8-16

Findings include:

A review of the Alzheimer's training program consists of all required elements, staff are trained in care of the cognitively impaired on new hire and do an additional module each quarter related to an aspect of Alzheimer's care.

During review of admission forms and documents provided to residents and their families upon admission to the facility indicated there was no information regarding Alzheimer's training.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 302	Continued From page 16 During an interview on 12/30/15, at 3:15 p.m. the director of nursing (DON) stated she reviewed the information with the administrator and verified they are not providing written information to consumers related to Alzheimer's training indicating they will start "working on it". SUGGESTED METHOD OF CORRECTION: The DON or designee could review their policies and procedures in addition to insuring updated information is being provided to residents and/or their families regarding Alzheimer's/Dementia training. Provision of training/notification could then be reviewed at the quarterly QA&A meeting. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 302		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care related to activities for 2 of 3 (R6, R23) residents reviewed for activities. Findings include: When interviewed on 12/29/15, at approximately	2 565	Completion Date: 2-8-16	2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 565	Continued From page 17	2 565		

8:50 a.m. the director of nursing (DON) confirmed R6 did not speak or understand English. DON further indicated staff communicated with the resident through gestures and facial expressions.

R6 was admitted to the facility on 9/5/14, with diagnoses including dementia without behavioral disturbance, cognitive communication deficit, chronic obstructive pulmonary disease (COPD), muscle weakness and difficulty walking per the facility diagnosis report.

R6's care plan for activities dated 10/12/15, indicated the resident was primarily independent but occasionally needed some guidance with structuring leisure activities that promote wellness. Interventions identified on the care plan:
(1.) CD player in room; please play music per resident's desire.
(2.) Recreation/Wellness preferences include: exercise, listening to music, watching TV (enjoys wrestling and war movies) food related activities, sensory and 1:1 time.
(3.) EMOTIONAL: Offer ipod or CD player for individual music enjoyment.
(4.) PHYSICAL: Encourage participation in Well-Fit program to include group exercise and/or individual cardio. The activity goal indicated R6 would work on puzzles in day room by the review period.

On 12/29/15, R6 was observed continuously from 1:16 p.m. until 4:17 p.m.

- At 1:16 p.m. R6 was ambulated with the assistance of two staff, a 3rd staff pushed the residents wheelchair (w/c) behind him down the west cityside hallway. After R6 ambulated the length of the hall staff seated him back in the w/c,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 565	Continued From page 18	2 565		

removed the transfer belt and transferred him to the dayroom area located by the nurses' station. Staff moved him in front to the television and then R6 propelled himself in the w/c throughout the dayroom.

-At 1:27 a.m. nursing assistant (NA)-A brought R6 a round shaped sensory item which consisted of multiple-colored hollow tubes held together with a bungy type cord. This enabled the object to be stretched and manipulated. R6 accepted the item, talking out loud constantly. Although R6 held the item, he did not appear interested nor did he attempt to manipulate or pull the sensory item. NA-A left the area after the item was delivered to R6.

-At 1:34 p.m. a staff member transported R6 from the middle of the dayroom to a table with another resident. R6 continued to verbalize while the sensory object remained on his lap. No interaction between staff and R6 occurred. R6 remained at the table a short time and then began to propel the w/c around the dayroom.

-At 2:00 p.m., R6 was observed lying in bed on top of covers with shoes on. The sensory item given to him earlier was placed on his legs. R6 was not touching nor handling the item even though he appeared to be wide awake. At this time, a popcorn and movie activity was occurring in the activity room.

-At 2:07 p.m. it was noted that R6 was sitting up on edge of bed with feet dangling down; the sensory item remained on resident's lap. It was again noted that R6 was not touching nor interested in this sensory object.

-At 2:14 p.m. staff entered the room to distribute

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 565	Continued From page 19	2 565		

fresh water, greeted R6 and left immediately.

-At 2:30 p.m., R6 was seated on the edge of his bed in room with the left shoe off and was holding a shoe on his lap, removing the laces. The sensory object was no longer visualized. No music was playing in the room.

-At 2:39 p.m., R6 remained seated at the edge of the bed attempting to pull the laces from his left shoe. R6 had a nebulizer mask on and no staff were present in the room during this observation. Coffee social and word games activities were held in the dining room at this time.

-At approximately 2:50 p.m., LPN-D in R6's room attending to the nebulizer machine while R6 continued to sit on edge of bed attempting to remove the laces from his left shoe. At 2:56 p.m. R6 remained seated at the edge of bed holding onto the unlaces left shoe. At 3:10 p.m. NA-C entered the room and greeted R6. Trained medication aide (TMA)-A also entered the room and asked whether R6 was still "working on his shoe". NA-C asked TMA-A whether R6 was supposed to have the shoe. TMA-A responded that if NA-C could get it laced and on R6, they could transfer him into his chair and not worry about it. On 12/29/15, at 3:57 p.m. R6 remained seated on the side of bed, holding his left shoe without laces. R6 appeared to be examining the shoe. The Wellness group was on the activity schedule for 4:00 p.m. At 4:17 p.m. R6 remained seated on edge of bed, holding onto the left shoe and was attempting to replace the laces back in the shoe. This activity had been continuous since 2:30 p.m. (almost 2 hours).

R6 was not offered/assisted to scheduled activities during the 3 hours of continuous

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 565	Continued From page 20	2 565		

Continued From page 20

observation on 12/29/15. The plan of care was not followed as written. R6 was handed a sensory object though staff failed to model how object could be used and/or spend time any time with R6.

It was observed on 12/30/15, at 10:04 a.m. a church activity was conducted in the activity room. R6 independently propelled himself down the west hallway but once R6 turned the corned, the administrator redirected and propelled him back down the direction of the hallway. R6 then entered the dayroom, propelling self around the perimeter of the area, pausing to look out the window and then watched the activity in the fish tank. R6 propelled self toward the direction of the east hallway and remained seated near this area until 10:30 a.m. LPN-C then moved R6 from the east hallway to a table located in the dayroom. No verbal communication nor interaction was noted between staff and R6. R6 was not offered/assisted to the church activity at anytime throughout the noted observations nor did staff interact with the resident.

On 12/30/15, at 11:07 a.m. R6 was observed seated in w/c in dayroom by nurses station; Wellness activity was currently in process and was identified on the plan of care as an planned intervention.

At 11:27 a.m. R6 was seated in w/c in cityside dayroom near nurses station when the activity director (AD) entered the dayroom, said "Hi" to R6, turned up the volume on the TV and walked away. At 2:35 p.m. R6 was observed in the dining room where the men's group activity was held in the main area of the dining room. R6 was served a snack while located in the front area of the main dining room, partitioned off by a wall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 565	Continued From page 21	2 565		

with 2 openings. R6 was offered his snack at the table where he routinely consumed his meals. R6 was left alone in the front area of the dining room while the other residents were served their snack in the main area. At 2:41 p.m. when R6 finished his snack, propelled himself around the front area of the dining room near his designated table. No activity staff were noted to interact with R6 until they assisted out of the dining room towards the direction of his room at 2:44 p.m.

When interviewed on 12/30/15, at 12:41 p.m. the AD stated R6 is very "antsy" r/t group activities and is scheduled for in-room programming. AD further indicated that 2 in-room activity programs were scheduled for 20 minutes/day. AD also stated staff will also offer coffee social time as well as the men's group activity as well as three 1:1 visits weekly.
When questioned about the preferred activities (wrestling and war movies) documented on R6's care plan, she indicated being unaware of these preferences. When the current activity sheets were reviewed to substantiate the activities each resident had attended, there was nothing highlighted and/or documented indicating that R6 had been involved in activities during the days of observations.

When further interviewed on 12/31/15, at 10:21 a.m. the AD provided 10 days of December 2015 activity sheets which indicated R6 was offered activities on 8 of the 10 days. AD stated the activity sheet dated 12/21/15, indicated the resident was offered the exercise activity. AD stated she sat next to R6 during the activity and he did really well. However, the AD was unable to provide documentation of activities offered in November 2015 and provided 5 days of activity sheets for October 2015. It was confirmed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 565	Continued From page 22	2 565		

plan of care was not implemented as written.

R23 was admitted on 1/6/15 with diagnoses including: dementia, paranoid personality, mood disorder, and chronic obstructive pulmonary disease (COPD) per the facility diagnosis report. The report further identified R23 was admitted to hospice services on 5/15/15 due to senile degeneration of the brain.

R23's care plan last revised 11/9/15, indicated the resident was dependent on staff for structuring and providing activities that promote wellness stimulation due to cognitive deficits. Interventions included: (1) "1 to 1 bedside/in-room visits and activities if [resident name] is unable to attend out of room events. (2) COGNITIVE: Encourage participation in small groups and/or 1:1 interactions (3) EMOTIONAL: Offer ipod or CD player for individual music enjoyment. (4) ENVIRONMENTAL: Observe [resident name] body language related to overstimulation [Resident name] Recreation/Wellness individual preferences include Bingo, walks, magazines, word search, TV and listening and playing music."

R23 was observed continuously on 12/29/15, from 1:14 p.m. until 3:56 p.m. while lying in bed. A popcorn and move activity was held at 1:30 p.m. in the activity room and the coffee social activity held at 2:30 p.m. in the dining room. Staff did not offer R23 the opportunity to attend either activity.

R23 was again observed continuously on 12/30/15, from 10:03 a.m. until 10:23 a.m. At 10:03 a.m. R23 was seated in a geri chair in the cityside dayroom at a table while a church service was currently being held in the activity room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ____ B. WING ____	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 565	Continued From page 23	2 565		

At 10:21 a.m. R23 remained in the geri-chair with eyes closed. The AD approached another resident seated in w/c located near the cityside nurses station and asked whether she wanted to attend church. R23 opened her eyes when the AD and the resident left for church but looked away and closed her eyes when they left the area. NA-A then approached R23 at 10:23 a.m. to ask whether she wanted to lay down; R23 nodded "yes". NA-A did not give her the opportunity to attend the church activity before transporting her to her room.

At 11:08 a.m. R23 was observed lying in bed with eyes closed while a Wellness activity was in process. She had not been given the opportunity to attend this activity.

At 3:12 p.m. R23 was again lying in bed with eyes closed. A music activity was being performed in the cityside dayroom with a resident's family member piano playing. Staff were not observed to offer attendance to the activity to R23.

When interviewed on 12/30/15, at 11:55 a.m. NA-B and NA-A confirmed they had assisted R23 with her morning cares, stating that when offered activities, she often refuses as prefers to lie down. Both NA's confirmed they had not offered R23 attendance at the morning church activity as R23 had been tearful that morning when receiving care and they felt the resident would rather lie down.

When interviewed on 12/30/15, at 1:40 p.m. the AD stated R23's activities included hair care, a daily Sunshine group (sensory group) which is implemented twice daily Monday-Friday and once on Saturdays). AD confirmed she would still expect R23 be offered the opportunity to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 565	Continued From page 24	2 565		

participate in attending church. AD attempted to located documentation of activities attended and 1:1's provided for R23. The 1:1 activity sheets indicated R23 was to have 1:1's three times/weekly. AD provided 1:1 documentation from 11/2/15 - 12/5/15 (minus the week of 11/16/15 - 11/22/15); R23 was provided a 1:1 on 7 occasions during this period (11/5/15, 11/7/15, 11/12/15, 11/13/15, 11/27/15, 12/4/15, 12/7/15).

When interviewed on 12/31/15, at 10:21 a.m. the AD provided 10 days of December 2015 activity sheets for 23. The sheets indicated R23 was offered activities on 5 of the 10 days. AD was unable to provide documentation of activities offered in November 2015 and provided 5 days of activity sheets for October 2015. The activity sheets did not include evidence if the resident had participated or refused the activity; AD confirmed the charting of activities was incomplete. The plan of care was not implemented as written.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility develops care plans according to the residents individualized needs. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. The results of these audits could then be presented at the quarterly QA&A meetings.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 25	2 830		
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 by: Based on interview and document review, the facility failed to provide adequate nursing care and services for 2 of 4 residents (R46, R21) reviewed who had been hospitalized. This resulted in actual harm for R46, who experienced prolonged discomfort, dehydration and vomiting related to delayed nursing assessment and transfer to an inpatient facility for a small bowel obstruction. In addition, the facility failed to provide appropriate interventions related to dementia care for 1 of 1 resident (R6) reviewed who had dementia and could not speak/understand English. Findings include: R46's discharge orders to the nursing home dated 9/17/15, identified a discharge condition of improving with orders for physical and occupational therapy.	2 830	Completion Date: 2-8-16	2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 26	2 830		

R46's physician's progress notes, dated 9/18/15 indicated diagnoses of spinal stenosis of the lumbar region, sepsis, and urinary tract infection. The physician's progress note also identified a history of diverticulitis of the colon.

R46's admission Minimum Data Set (MDS), dated 9/24/15 identified a Brief Interview for Mental Status score of 13/15 (cognitively intact). No care area assessments were completed with the MDS.

R46's care plan, dated 9/30/15 identified no cognitive impairments and that R46 desired to return to the community.

R46's September 2015 medication sheets revealed R46 had received Maalox (an antacid) 30 cubic centimeters (cc)'s on 9/25/15 a total of four times on that date, as well as one dose at 2:00 a.m. on 9/26/15. Notations documented by licensed practical nurse (LPN)-A, on the back of the medication administration record for a dose administered on 9/25/15, at 2:00 a.m. indicated the medication had been given for stomach upset since supper. No follow up assessment for effectiveness was completed. A subsequent entry dated 9/26/15, at 2:00 am. indicated R46 had received another dose of Maalox for an upset stomach and emesis; the follow up result was listed as had another emesis at 4 a.m. None of the other doses administered had follow up results documented.

A nursing progress note written by LPN-F on 9/25/15 at 8:30 a.m., indicated R46 had hiccups and complaints of not feeling well. The notes indicated R46 had been given Maalox 30 cc's along with Thorazine and had begun retching after his morning medications. In addition, R46

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 830	Continued From page 27	2 830		

had experienced a large projectile emesis all over the bed and himself, and had refused to eat anything for breakfast, stating he had consumed orange juice that had all come up.

A nursing progress note documented by LPN-F on 9/25/15, at 1:39 p.m. indicated R46 had a large emesis, and that the resident had stated he was not feeling well. The notes indicated his hiccups had subsided for a while but had then started again. Documentation indicated R46 had received Maalox and Thorazine (an antipsychotic medication used for antiemetic properties) with another small emesis afterward. The emesis was documented as having had food particles present and was described as having a colicky odor. R46's temperature was documented as having been elevated at 99.0 degrees Fahrenheit (F).

A nursing progress note dated 9/25/15, at 6:00 p.m. per LPN-F indicated R46 had stayed in bed most of the evening. The note indicated R46's hiccups were better over the early evening hours but that R46 had been stated his tummy still didn't feel right and that whenever he moved he began to gag. R46 had eaten Jell-O for supper and had sips of water. Additionally, the documentation indicated a fax (facsimile) had been sent to medical doctor (MD)-A with an update on R46's condition including that R46 had an elevated temperature at 99.5 degrees F and complained of feeling chilly.

A nursing progress note dated 9/25/15, at 11:05 p.m. per LPN-F indicated R46 had not been feeling well, and had been having brown colored emesis twice on the afternoon shift which did not appear to have a feces odor. Maalox 30 cc's had been given to help with hiccups and R46's vitamins had been held due to emesis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ____ B. WING ____	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 28	2 830		

A nursing progress note by LPN-A, dated 9/26/15, at 1:56 a.m. indicated R46's abdomen was distended, his bowel sounds were difficult to hear and he had been having emesis which looked like BM. R46's temp was noted to be slightly elevated at 99.1 degrees F.

A nursing progress note written by LPN-A on 9/26/15, at 4:48 a.m. indicated R46 had 100 cc's of emesis, like soft formed/loose BM (bowel movement) with no odor. The note further indicated R46 was cool and clammy, with a slightly elevated temperature at 99.1 degrees F. R46 had a wastebasket beside him, and continued to wretch.

A nursing progress note entered by LPN-B, dated 9/26/15, at 9:57 a.m. indicated R46 had two further emesis of greenish liquid thick with pieces of BM looking in it. In addition, the note indicated an acute care hospital had been called and an order was received to transfer R46 to their emergency room (ER) via ambulance. The note indicated R46's daughter was updated and had agreed to meet him at the hospital. R46 left the facility at 8:45 a.m.

A faxed physician's order dated 9/26/15 was present in R46's record and verified the physician order to transfer per ambulance to the acute care hospital.

An additional nursing progress note dated 9/26/15, at 2:06 p.m. indicated R46 had been admitted to the acute care hospital with a diagnoses of bowel obstruction, and would need surgery.

A faxed physician's order sent on 9/25/15, at 6:05

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 29	2 830		

p.m. from the facility to R46's primary physician identified that R46 had emesis since 8:30 a.m., experienced several rounds of hiccups throughout the day and had been unable to eat or drink. R46 complained of feeling weak. The fax had not been signed off until on 9/28/15, three days later, when the nurse practitioner (NP)-A responded with a statement including, "Noting telephone order to transfer to ER on 9/26/15. Please do NOT fax in regard to situations that need attn [attention] that day. This will be sent to [physician] - today 9/28/15. Please review the faxing for response procedure. Thx [Thanks]."

The ER progress note dated 9/26/15, at 10:36 a.m. was reviewed. The ER note indicated R46 had appeared distressed when examined, had been uncomfortable, and had dry oral mucous with dried brown material on the tongue and lips. The ER note further indicated R46's abdomen was firm and diffusely distended, mildly tender with no appreciable bowel sounds. In addition, 1800 milliliters (ml) of brown liquid had been drained from R46's stomach after the insertion of a nasogastric tube. R46 had received 2000 ml of normal saline intravenous for hydration. The ER physician's note indicated R46 had appeared quite dehydrated and verified the admitting diagnoses of small bowel obstruction and severe dehydration.

The ER registered nurse's assessment dated 9/26/15, at 11:17 a.m. indicated: R46 had stated he'd been vomiting for the last two days and his emesis was now brown like stool. R46 had vomited three times in the ambulance enroute to the ER and the vomit was described as dark brown liquid running out of his mouth. R46's abdomen was very firm, with no bowel sounds and the abdomen was distended. R46

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 830	Continued From page 30	2 830		

complained of abdominal pain but was unable to rate the pain. R46 had his stomach drained via a nasogastric tube for ten minutes with 1400 mL of fluid output after which R46 stated he felt much better. R46 was alert and "states we should do what ever we have to do. Is comfortable now."

The hospital discharge summary dated 10/5/15, indicated R46 had undergone abdominal surgery to correct the small bowel obstruction, and had developed subsequent cardiac and anticoagulation issues as well as post-operative ileus (disruption in normal bowel motility) after the surgery. The ileus resolved with the replacement of a nasogastric tube; however, comfort cares were initiated and R46 passed away on 10/5/15.

During interview on 12/29/15, at 3:07 p.m. the director of nursing (DON) verified she would have expected staff to contact the on-call doctor immediately with the urgent clinical issues, especially when the resident was vomiting BM-type material and not feeling better.

During interview on 12/29/15, at 3:32 p.m. the nursing home's health information coordinator/nursing scheduler (HIM) stated LPN-B was not well and was currently in a hospital intensive care unit, unavailable for interview. The HIM verified LPN-F had been a pool nursing staff.

During interview on 12/29/15, at 3:45 p.m. the acting administrator, who had been the DON at the time of the incident stated she'd thought R46's family had indicated he was admitted to the hospital with a bowel obstruction, but that it had later been found to be a narrowed bowel. The administrator was unable to recall specifics regarding R46's episode of illness; however,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 31 stated she would have expected staff to contact/call the on-call and/or primary physician directly with concerns that were urgent. The administrator stated she would have expected the staff to check the vital signs, bowel movement status, appetite and fever status while conducting a physical assessment. The administrator stated she thought LPN-A was a good nurse and trusted her judgment. She further verified LPN-A worked every Thursday night shift. When LPN-A was interviewed about the incident on 12/29/15 at 4:02 p.m., LPN-A stated she'd received report from the evening nurse (LPN-F) on 9/25/15, regarding R46's emesis, but had been unaware a fax had been sent. LPN-A stated she'd worked with R46 at least one time prior and was aware R46's vomiting and complaints of not feeling well was new for R46. She was aware R46 had thrown up and had not been eating well, and had subsequently administered Maalox during the night. LPN-A thought the Maalox had helped somewhat the first time she administered it (around 2:00 a.m.). LPN-A verified R46 had emesis of what looked like stool but there was no odor. She verified his abdomen had also seemed a little distended. LPN-A was unaware whether R46 had complained of pain. LPN-A said R46 subsequently vomited and it looked more like BM later in her shift (around 5:00 a.m.) at which time she'd become concerned that he may have something wrong with his small bowel. LPN-A said she'd proceeded to fill out all the transfer paperwork for a hospital discharge; however, did not call the RN on call nor notify the physician of her concern. LPN-A indicated she had passed along the paperwork and her concern to the day nurse, LPN-B, who arrived on duty at 6:00 a.m. on 9/26/25. LPN-A stated she'd told LPN-B to do	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 32	2 830		

an assessment to follow up on R46's condition. During the interview, LPN-A stated she thought there had been a history of small bowel concerns she had noted when filling out the paperwork to pass along to the day shift personnel.

During a follow up interview on 12/30/15, at 9:12 a.m. the administrator stated LPN-A should have notified the physician sooner about R46's symptoms, and that she had not been aware there had been a delay in his nursing care and physician notification of his condition.

During interview on 12/30/15, at 2:11 p.m. the medical director was interviewed and stated she would have expected nursing staff to call when they filled out the paperwork to transfer R46 to the hospital. The medical director stated although R46 may have subsequently expired anyway, prompt medical care would have made him comfortable. The medical director stated the effect of delayed medical care/interventions related to R46's medical outcome was difficult to state since she was not his usual physician.

During interview on 12/31/15, at 9:27 a.m. medical doctor (MD)-A (R46's usual physician) stated he would have expected staff to have called the clinic and/or the on-call physician when R46 began vomiting stool-like material. MD-A stated faxing medical staff at the clinic at 6:00 p.m. was inappropriate as the fax machine was not attended at that time of day. MD-A stated he'd been concerned about the potential for ischemic bowel when R46 arrived at the hospital, due to the delay in receipt of medical attention after his symptoms began. MD-A stated R46 had made some "depressed" comments prior to the hospital transfer on 9/26/15, but those comments were a "sidebar" and were not relevant to this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 33	2 830		

issue. MD-A confirmed R46 would have been more comfortable if he had been examined sooner in the ER. MD-A stated, "when you are vomiting brown stuff, it is probably a good idea if you are seen."

The facility's policy entitled Change in Condition SBAR last revised 3/15, indicated immediate notification of the physician was required for any symptom, sign or apparent discomfort that was sudden in onset, a marked change (i.e. more severe) in relation to usual signs and symptoms and was unrelieved by measures already prescribed. The policy further indicated in a section related to abdominal distension that immediate notification of the physician was required when there was rapid onset, or presence of marked tenderness, fever, vomiting or GI (gastrointestinal) bleeding.

Review of R21's Medication Administration Record (MAR) dated December 2015, identified that blood sugar (BS) readings were monitored five (5) times per day. Between the dates of 12/1 - 12/29/15 there were 44 blood sugar (BS) levels which were documented as 400 milligrams (mg)/ deciliter (dL) and above, with 25 of those documented BS level readings higher than 430 mg/dL. Although the resident's blood sugars fluctuated dramatically, there had not been physician notification of blood sugars which registered greater than 430 mg/dL.

A physician's order, dated 11/3/15 indicated, Insulin Regular Human Solution 100 unit/milliliter (ml) Inject as per sliding scale with the final ordered dosage "greater than 400 mg/dL: give 6 units".

A physician's order, dated 12/7/15 indicated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 34	2 830		

Insulin Glargine Solution 100 unit/ml- 24 units subcutaneous (SQ) one time per day (QD), and sliding scale with Regular Humalog solution 100 unit/ml. BS readings were to be faxed to the diabetic educator weekly. No parameters were listed for notification of the physician regarding hypo (low) or hyper (high) glycemia (BS).

During interview on 12/30/15, at 3:10 p.m. a licensed practical nurse (LPN)-C indicated there were no protocols, or orders, indicating when to notify the medical doctor (MD) of BS levels. LPN-C stated she would notify the MD related to how the resident felt and if there was a high BS-which she identified as "way above 400's-500's".

On 12/30/15, at 2:36 p.m. LPN-D stated she would notify the MD if she obtained a BS result above 600 mg/dL. LPN-D confirmed on 12/29/15, the supper BS check for R21 was 521 mg/dL and the MD was not updated. LPN-D further stated R21 frequently has BS readings above 400 mg/dL and the facility standing orders read to give 6 units of regular insulin if the BS was greater than 350 mg/dL. LPN-D indicated when the glucometer read "high" it was the result of a BS over 600 mg/dL and she would telephone the nurse on call at the hospital to report the reading.

During interview on 12/30/15, at 2:57 p.m. the diabetic educator indicated she received weekly reports of R21's BS results. She further stated the clinic has a protocol for diabetic medication adjustments and this was what insulin changes were based upon. The diabetic educator further stated R21 had a history of being a brittle diabetic and nursing staff were supposed to call the medical provider on call and/or the triage nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 830	Continued From page 35	2 830		

related to changes in status. The diabetic educator further indicated she thought BS parameters had been identified when R21 was recently discharged from the the hospital on 12/5/15. She indicated the parameters would have been determined by the discharging MD.

During interview on 12/30/15, at 3:12 p.m. RN-B and RN-C stated there were facility parameters for reporting BS readings. They referenced the documentation on the facility's standing orders and stated that would be the practice they followed unless individualized orders were written. RN-B indicated if a resident was symptomatic she would notify the physician based on the standing order instructions. RN -B and RN-C indicated they were not aware of the Change in Condition policy related to immediate reporting of BS readings above 430 mg/DL. RN-B stated, "we will have to make certain everyone is aware of this policy".

During interview on 12/31/15, at 8:36 a.m. LPN-E indicated she had been employed as an LPN for 3 months at the facility and had received training on BS checks which included: to test in a private area, wear gloves, and follow MD orders if the resident had orders for a sliding scale (SS), or a specific insulin order. LPN-E stated if there was a "high" reading she would contact the MD on call for direction. In the instance of a 400+ reading for R21 LPN-E indicated she would administer the ordered SS dose and recheck in one hour and then recheck in the following hour to determine whether the BS was responding to insulin. LPN-E stated she would probably not notify the MD in this instance as this resident has a history of BS fluctuations. LPN-E further indicated R21 did not have specific orders for follow up but this is what she would do.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 36	2 830		

Continued From page 36

On 12/31/15, at 9:04 a.m. R21's physician, also the facility's medical director, stated typically a resident would have a specific order that comes from the hospital for sliding scale insulin. R21's physician stated R21 had been her patient even before admission to the nursing home, and had a history of blood sugars fluctuating "all over" but that the resident was usually most comfortable when her blood sugars ran over 300 mg/dl. However, stated if she'd received a telephone call for an elevated blood sugar level she could provide specific orders as to when staff were required to recheck the BS and call back the results. She stated, "they call if the meter reads 'hi' because they have nothing to base it off. If the blood sugar is below 70 mg/dL staff would need to initiate the hypoglycemia protocol." She further indicated she would expect staff to notify the clinic and/or on-call staff to update on BS readings that were outside range.

When interviewed on 12/31/15, at 1:00 p.m. the director of nursing (DON) reviewed the December 2015 documentation of R21's BS readings and indicated she was unaware of the wide fluctuation of BS readings for R21 which were over 430 mg/dL. She confirmed she would have expected staff to notify the attending MD and/or the on-call staff in accordance with the Change in Condition When to Report to the MD/NP/PA policy.

The facility's policy related to physician notification for blood sugar fluctuations, entitled, Change in Condition When to Report to the MD/nurse practitioner(NP)/physician assistant last revised 3/15, included: "blood sugars greater than 430 mg/dL (or machine registers high) in diabetic patients using sliding scale insulin should be immediately reported to the physician or nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 37	2 830		

practitioner (NP)."

When interviewed on 12/29/15, at approximately 8:50 a.m. the DON confirmed R6 was unable to understand or be understood, and staff communicated using gestures and facial expressions.

The facility diagnostic report indicated R6 was admitted to the facility in 2014, with diagnoses including dementia without behavioral disturbance with a cognitive communication deficit.

R6's annual MDS assessment dated 10/9/15, revealed the resident had severely impaired cognition with daily wandering that significantly intruded on the privacy of others, physical behavior towards others 1-3 days, other behavior not directed towards others 4-6 days but less than daily. The MDS also indicated R6 required extensive assistance with bed mobility, transfer, locomotion on/off unit, dressing, toilet use, and personal hygiene. The MDS further indicated neither the resident nor family/significant other was able to complete the daily and activity preference portion of the assessment.

R6's care plan dated 10/12/15, indicated a risk for falls related to (r/t) history of falls, generalized weakness, gait/balance problems, bladder incontinence, hearing and vision impairments, impaired cognition, and difficulty communicating needs. Interventions included: anticipate and meet needs, encourage activities that promoted exercise, physical activity for strengthening and improved mobility, ambulate with staff in hallway three times daily, redirect when wheeling close to wall or objects, use distraction when restless. The care plan further identified a communication problem r/t hearing deficit and head injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 830	Continued From page 38	2 830		

Interventions included: discuss with resident/family concerns or feelings regarding communication difficulty, family reported that they were unable to communicate with resident due to the progression of his dementia, observe effectiveness of communications strategies and assistive devices.

On 12/29/15, R6 was continuously observed from 1:16 to 4:17 p.m.:
- At 1:16 p.m. R6 was observed being ambulated by two staff with a third pushing the resident's wheelchair (w/c) behind him down the west "Cityside" hallway. The resident was cooperative while walking and although could not be understood, spoke and smiled to the staff, who in turn talked to the resident. After walking the length of the hall, the resident was assisted back to the dayroom in front of the television (TV). R6 then propelled himself throughout the dayroom in his w/c.

-At 1:27 p.m. NA-A brought R6 a sensory item that was rounded in shape and consisted of multiple-colored hollow tubes held together with a -type cord enabling the object to be stretched and manipulated. R6 accepted the item, talking out loud constantly and NA- walked away. R6 held the item but did not appear interested, nor did he attempted to manipulate the object.

-At 1:34 p.m. a staff member transported R6 from the middle of the dayroom to a table with another resident. R6 continued to verbalize while the sensory object remained in his lap. No interaction with staff and R6 was observed. R6 remained at the table for a short time and then began to propel himself in w/c around the dayroom.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 39	2 830		

-At 1:44 p.m. R6 started to propel behind the nurses' station. LPN-C redirected the resident away from the area and then assisted him to his room.

-At 1:52 p.m. R6 propelled himself out of his room to the drinking fountain in the west hallway. R6 had a plastic mug and was attempting to obtain water from the fountain. A staff member approached R6 and assisted him with filling the mug with water then replaced the cover on the mug. R6 accepted the water mug then continued to mumble out loud and propel himself down the west hallway towards the administrative offices. Once R6 made it to the end of the hallway, staff intercepted the resident and returned him to his room.

-At 2:00 p.m., R6 was lying in bed on top of covers without shoes. A sensory item the resident was holding earlier was on the resident's legs. R6 eyes were wide open.

-At 2:07 p.m. R6 was sitting up on the edge of the bed with feet dangling, and the sensory item was on his lap. The resident was not touching or paying attention to the sensory object.

- At 2:30 p.m. R6 was seated on the edge of his bed. His left shoe was off his foot, as he held his other shoe and pulled out the laces.

-At 2:39 p.m., R6 continued to sit on the edge of bed in room attempting to pull the laces out of his left shoe. Coffee social and word games activity was being conducted in the dining room at that time. At 2:56 p.m. R6 continued to sit on edge of bed having successfully removed the laces from his shoe. At 3:10 p.m. NA-C entered R6's room and greet him. A trained medication aide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 40	2 830		

(TMA)-A entered the room and asked if the resident was still "working on his shoe." NA-C asked if R6 was supposed to have the shoe. TMA-A responded that if she could get it laced and on the resident, then they could put him in his chair and not worry about it. On 12/29/15, at 3:57 p.m. R6 seated on side of bed examining the unlaced shoe. A wellness group was scheduled to begin at 4:00 p.m. On 12/29/15, at 4:17 p.m. R6 was still on the edge of the bed, attempting to re-lace his shoe. This activity had been continuous since 2:30 p.m. or nearly two hours.

R6 was not approached and/or involved in any significant staff to resident communication during the three hour continuous observation on 12/29/15. The resident was handed a sensory object though staff failed to model how object could be used or spend time with the resident. Staff provided minimal interaction with R6 and continually redirected him to his bedroom and eventually put into bed though the resident was wide awake.

R6 was observed on 12/30/15, during the following times:
- At 7:50 a.m. R6 was seated alone at a table in the corner of the dining room eating breakfast independently. The table was pushed flush to the wall on two sides. R6's back was to the other residents as he faced the wall.

- At 7:58 a.m. R6 was assisted in the w/c by staff to the Cityside dayroom and was situated at a table. Staff handed R6 a multicolored cylinder shaped sensory object that also made sound when manipulated. Staff then left the area without further interaction. R6 placed the object behind him on the seat of his w/c and proceeded to propel himself past the nurses' station towards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 41 the dining room to the medication cart where LPN-C was standing. Although R6 could not be understood, he vocalized loudly. LPN-C informed R6 he had already eaten and assisted the resident back to his room. LPN-C left the resident's room at 8:05 a.m. R6 was lying on the bare mattress and pillow without a pillowcase. The bedding was piled at the end of the bed. R6 was holding onto the grab bar, attempting to sit up in bed. -At 8:25 a.m. R6 was seated at the edge of the bed and the w/c was positioned next to bed with the brakes locked. R6's tennis shoes were located on the seat of the w/c. At 8:36 a.m. R6 was wearing shoes, and was ambulating along the side of the room as he felt the wall. The surveyor alerted the administrator who was walking by to question whether R6 was capable of independent ambulation. The administrator stated R6 did sometimes ambulate, and redirected R6 to his wheelchair. The administrator asked R6 whether he needed his oxygen (O2) as he was heavily breathing. The O2 was applied via a nasal cannula and the administrator left the room. - At 8:49 a.m. R6 removed the 02 tubing, propelled himself from the room via the w/c and entered another resident's room located across the hall. Upon entering the doorway, housekeeping (Hspkg)-A intervened and redirected R6 back to his own room. -At 10:04 a.m. a church activity was conducted in the activity room. R6 independently propelled himself down the west hallway but once he turned the corner, the administrator redirected and propelled him back down the direction of the hallway. R6 then entered the dayroom, propelling	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ____ B. WING ____	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 830	Continued From page 42	2 830		

himself around the perimeter of the area, pausing to look out the window and watched the fish in the fish tank. R6 propelled himself toward the direction of the east hallway and remained seated here until 10:30 a.m. LPN-C then moved R6 from the east hallway to a table located in the dayroom. No verbal communication nor interaction was noted between staff and R6.

-At 11:07 a.m. R6 was seated in w/c in dayroom by nurses station. A wellness activity in process and was identified on the plan of care as an planned intervention. At 11:27 a.m. R6 was seated in w/c in Cityside dayroom near nurses station when the activity director (AD) entered the dayroom, said "Hi" to R6, turned up the volume on the TV and walked away. At 11:48 a.m. R6 remained seated at the table in the corner of the dining room with his back away from the other residents.

-At 2:16 p.m. NA-B and NA-A attempted to assist R6 to ambulate, however, the resident did not stand when prompted for approximately 30 seconds. The transfer belt was removed and the staff left the resident.

-At 2:35 p.m. R6 was in the dining room where the men's group activity was held in the main area of the dining room. R6 was served a snack while located in the front area of the main dining room, partitioned off by a wall with two openings. R6 was offered his snack at the table where he routinely had been served meals, alone and away from the other residents who were served their snacks in the main dining area. At 2:41 p.m. when R6 finished his snack, propelled himself around the front area of the dining room near his designated table. No staff interacted with R6 until he was assisted out of the dining room towards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 830	Continued From page 43	2 830		

the direction of his room at 2:44 p.m. When interviewed on 12/30/15, at 12:41 p.m. the AD cited a communication barrier.

When interviewed on 12/20/15, at 3:36 p.m. TMA-A indicated they were unable to communicate with the resident and had not attempted any alternative method, and said it was unfair to R6. TMA-A said R6's family visited approximately monthly.

When interviewed on 12/31/15, at 8:50 a.m. the licensed social worker (LSW) and DON stated they were unsure whether R6 would have been able to talk to his family on the telephone. Although they had never attempted to assist him to contact his family, they said it would be worth attempting.

When interviewed on 12/31/15, at 1:25 p.m. the DON confirmed the R6 should not have been returned to his room or put into bed when he wandered. The DON stated, "That's sad" when informed the resident had been put into bed with a bare mattress, linen pushed to the end of the bed, and no pillowcase on the pillow. The DON agreed staffs' interventions and/or lack of appropriate interventions was concerning.

SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are monitoring and providing cares as necessary to meet the needs of residents. The director of nursing or designee could monitor for compliance through audits of medical records. The results of these audits could then be presented at the quarterly QA&A meetings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ____ B. WING ____	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 830	Continued From page 44 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were implemented to prevent significant weight loss for 1 of 3 residents (R28) reviewed for nutritional status. Findings include: R28's physician order sheet dated 7/1/15, revealed diagnoses including stroke, chronic kidney disease and dementia. The quarterly Minimum Data Set (MDS), dated 12/11/15 revealed R28 had a weight loss of 5% in the past month or 10% in the past 6 months. The residents current weight at 150#. No chewing or eating problems. The MDS further identified R28 had experienced a weight loss of 20# pound (lb) from the previous MDS dated 9/16/15, of a significant change.	2 965	Completion Date: 2-8-16	2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 965	Continued From page 45	2 965		

Review of the most current care plan identified R28 as having potential nutritional problems due to dementia and decreased cognition. Interventions listed include: staff assist to set up residents meals, monitor the residents intake and report any changes to the physician, monitor the residents weights and report to the physician any significant weight loss and allow the resident time to eat in a calm setting.

Review of R28's log of weights revealed a 20 lb loss from 170 to 150 lbs. between 9/15 and 12/15 (3 month period).

Review of R28 nutritional assessment dated 10/14/15 indicates the residents weight was at 170#. The resident eats an average 75-100% of his meals and is on a regular diet with no chewing or swallowing problems.

Review of R28's mini nutritional assessment dated 12/14/15, with a significant change indicates the residents food intakes are stable and has not declined. The resident is showing a weight loss of 20# in the past 3 months and is at risk for malnutrition. No other information was documented related to causal factors nor interventions related to the weight loss.

Review of R28's dietary intakes for the previous 3 months revealed intakes ranging from 0-100% at meals. Average daily intake of food is 25-50%. The residents food intake log revealed the resident had an increased decline in eating for the months of 11/15 and 12/15.

R28's most current dietary progress note, completed by the dietician on 12/15/15, indicated the resident's significant weigh loss may be related to the residents increased dementia and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
2 965	Continued From page 46	2 965		

requiring more assistance with setting up his meals. No recommendations were provided.

During interview with the dietary director (DD) on 12/29/15 at 2:00 p.m., indicated she was unsure of who was responsible for monitoring R28's weights, but confirmed she had completed the most current MDS assessment which triggered/identified R28's significant weight loss. The DD stated R28's weight loss had been discussed with the registered dietician (RD) on 12/15/15, but the RD did not provide any recommendations.

During observations of R28 eating breakfast on 12/30/15, at 8:00 a.m. staff were feeding the resident his meal. The resident consumed 90% of his meal but did not participate in the process. The resident received a regular mechanical soft diet with no chewing or swallowing problems.

During interview with the facility RD on 12/30/15, at 8:00 a.m. she confirmed she was aware of R28's significant weight loss and stated the nursing staff indicated R28's weight loss was probably due to his dementia and he required more assistance with eating. The RD further included she did not recommend any type of intervention nor recommendation for R28's weight loss due to the residents body mass index (BMI) being within normal ranges. The RD further stated she was not concerned about a residents weight loss if they fall within their BMI, but may follow up the following month. When further questioned, the RD did confirm R28's significant weight loss should have been addressed by the staff for causal factors and follow up interventions.

SUGGESTED METHOD OF CORRECTION: The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
2 965	Continued From page 47 director of nursing or designee could review and revise current policies and procedures related to weight loss and residents nutritionally at risk. The director of nursing or designee could educate responsible staff on the policy changes as well as audit to ensure all current recommendations are being carried out within the dietary department. The director of nursing or designee could conduct audits for compliance and review with the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide activities for 2 of 3 (R6, R23) residents reviewed for activities. Findings include:	21435	Completion Date: 2-8-16	2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ____ B. WING ____	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
21435	Continued From page 48	21435		

R6
R6 was admitted to the facility on 9/5/14, with diagnoses including dementia without behavioral disturbance, cognitive communication deficit, chronic obstructive pulmonary disease (COPD), muscle weakness and difficulty walking per the facility diagnosis report.

R6's annual Minimum Data Set (MDS) assessment dated 10/9/15, indicated severely impaired cognition with daily wandering that significantly intruded on the privacy of others, physical behavior towards others 1-3 days, other behavior not directed towards others 4-6 days but less than daily. The MDS further indicated neither the resident nor family/significant other could complete the daily and activity preference portion of the assessment. The staff assessment of daily and activity preferences indicated the resident preferred receiving a tub bath, snacks between meals, staying up past 8:00 p.m., family or significant other involvement in care discussions, listening to music and spending time outdoors.

R6's annual Recreation/Wellness Assessment dated 10/4/15, indicated information was given by R6's son from the previous assessment. The assessment identified current interests as: group participation in intergeneration programs with specific interest with school kids singing, golf cart rides, visiting in person/on phone with family, walks/bicycling. The assessment also included past preferences of watching wrestling on TV and Charlie Chan movies.

R6's care plan for activities dated 10/12/15, indicated the resident was primarily independent but occasionally needed some guidance with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
21435	Continued From page 49	21435		

structuring leisure activities that promote wellness. Interventions identified on the care plan:
(1.) CD player in room; please play music per resident's desire.
(2.) Recreation/Wellness preferences include: exercise, listening to music, watching TV (enjoys wrestling and war movies) food related activities, sensory and 1:1 time.
(3.) EMOTIONAL: Offer ipod or CD player for individual music enjoyment.
(4.) PHYSICAL: Encourage participation in Well-Fit program to include group exercise and/or individual cardio. The activity goal indicated R6 would work on puzzles in day room by the review period.

When interviewed on 12/29/15, at approximately 8:50 a.m. the director of nursing (DON) confirmed R6 did not speak nor understand English. DON further indicated staff communicated with the resident through gestures and facial expressions.

Continuous observations of R6 on 12/29/15, from 1:16 p.m. until 4:17 p.m., revealed the following:

- At 1:16 p.m. R6 was ambulated with the assistance of two staff, a 3rd staff pushed the residents wheelchair (w/c) behind him down the west Cityside hallway. Staff were responding in English to his vocalizations. After R6 ambulated the length of the hall staff seated him back in the w/c, removed the transfer belt and transferred him to the dayroom area located by the nurses' station. Staff moved him in front to the television and then R6 propelled himself in the w/c throughout the dayroom.

- At 1:27 a.m. nursing assistant (NA)-A brought R6 a round shaped sensory item which consisted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
21435	Continued From page 50	21435		

of multiple-colored hollow tubes held together with a bungy type cord. This enabled the object to be stretched and manipulated. R6 accepted the item, talking out loud constantly. Although R6 held the item, he did not appear interested nor did he attempt to manipulate or pull the sensory item. NA-A left the area after the item was delivered to R6. R6 remained in the commons area until 1:44 p.m., when licensed practical nurse (LPN)-C assisted him back to his room.

-At 1:52 p.m. R6 left his room via the w/c to obtain water in his plastic mug from the drinking fountain located in the west hallway. Staff assisted him with the task, replaced the lid and left the area. With a water-filled mug, R6 continued to vocalize as he propelled the w/c down the west hallway. It was noted that once R6 arrived at the end of the hallway, staff intercepted and returned him back to his room.

-At 2:00 p.m., R6 was observed lying in bed on top of covers with shoes on. The sensory item given to him earlier was placed on his legs. R6 was not touching nor handling the item even though he appeared to be wide awake. At this time, a popcorn and movie activity was occurring in the activity room, however R6 was not assisted to attend. At 2:14 p.m. staff entered the room to distribute fresh water, greeted R6 and left immediately.

-At 2:30 p.m., R6 was seated on the edge of his bed in room with the left shoe off and was holding a shoe on his lap, removing the laces. The sensory object was no longer visualized. No music was playing in the room. From 2:39 until 4:17 p.m., R6 was observed attempting to remove and replace the lace from his left shoe. Although coffee social, wellness group and word

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
21435	Continued From page 51	21435		

games activities were held in the dining room at this time, R6 was not assisted or offered to attend. At 3:10 p.m. NA-C entered the room and greeted R6. Trained medication aide (TMA)-A also entered the room and asked whether R6 was still "working on his shoe". NA-C asked TMA-A whether R6 was supposed to have the shoe. TMA-A responded that if NA-C could get it laced and on R6, they could transfer him into his chair and not worry about it, however NA-C did not assist R6.

Observations of R6 on 12/30/15 revealed the following:

- At 7:50 a.m. R6 was observed seated alone at a table in the corner of the dining room eating breakfast independently. The table was pushed flush to the wall on 2 sides. R6 had his back to the other resident's in the dining room, facing only the wall. At 7:58 a.m. R6 was assisted in the w/c by staff to the Cityside dayroom and placed at a table. Staff handed R6 a multicolored cylinder shaped sensory object that also made sound when manipulated. Staff then left the area without further interaction. R6 placed the object behind him on the seat of his w/c and proceeded to propel self past the nurses' station towards the dining room to the medication cart where LPN-C was standing. LPN-C responded to R6 that he had already eaten and assisted in propelling him back to his room. LPN-C left the resident's room at 8:05 a.m. R6 was lying on his bed with the bare mattress exposed and bedding in a clump at the end of bed; no pillowcase was on R6's pillow. R6 was observed holding onto the grab bar, attempting to sit up in bed.

-At 8:25 a.m. R6 was seated at the edge of the bed and the w/c was positioned next to bed with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER: VALLEY VIEW MANOR HCC
STREET ADDRESS, CITY, STATE, ZIP CODE: 200 EAST NINTH AVENUE, LAMBERTON, MN 56152

(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) COMPLETE DATE
21435	Continued From page 52	21435		

the brakes locked. R6's tennis shoes were located on the seat of the w/c. At 8:36 a.m. R6 was observed ambulating in his room. R6 had shoes on and was feeling the wall as he walked along side the wall. The surveyor alerted the administrator who was walking by to question whether R6 was capable of independent ambulation. The administrator stated R6 does ambulate sometimes as observed and redirected R6 to his w/c. The administrator asked R6 whether he needed his oxygen (02) as he appeared to be breathing heavy. The 02 was applied via a nasal cannula and the administrator left the room. At 8:49 a.m. R6 removed the 02 tubing, propelled himself from the room via the w/c and entered another resident's room located across the hall.

-At 10:04 a.m. a church activity was conducted in the activity room. R6 independently propelled himself down the west hallway but once R6 turned the corned, the administrator redirected and propelled him back down the direction of the hallway. R6 then entered the dayroom, propelling self around the perimeter of the area, pausing to look out the window and then watched the activity in the fish tank. R6 propelled himself toward the direction of the east hallway and remained seated near this area until 10:30 a.m. LPN-C then moved R6 from the east hallway to a table located in the dayroom. No verbal communication nor interaction was noted between staff and R6. R6 was not offered/assisted to the church activity at anytime throughout the noted observations nor did staff interact with the resident.

-At 11:07 a.m. R6 was observed seated in w/c in dayroom by nurses station; Wellness activity was currently in process and was identified on the plan of care as an planned intervention. At 11:27

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
21435	Continued From page 53	21435		

a.m. R6 was seated in w/c in Cityside dayroom near nurses station when the activity director (AD) entered the dayroom, said "Hi" to R6, turned up the volume on the TV and walked away. At 11:48 a.m. R6 remained seated at the table in the corner of the dining room with his back to other resident's as noted during the breakfast meal.

-At 2:35 p.m. R6 was observed in the dining room where the men's group activity was held in the main area of the dining room. No activity staff were noted to interact with R6 until they assisted out of the dining room towards the direction of his room at 2:44 p.m.

When interviewed on 12/30/15, at 12:41 p.m. the AD stated R6 is very "antsy" r/t group activities and is scheduled for in-room programming. AD further indicated that 2 in-room activity programs were scheduled for 20 minutes/day. AD also stated staff will also offer coffee social time as well as the men's group activity as well as three 1:1 visits weekly. AD confirmed there was a language barrier related to attending activities and that an interpreter from the high school came to the facility on 12/4/15 but had not returned since. AD stated trying to get hold of the interpreter but calls had not been returned. AD stated a few weeks ago a representative from another facility came to assess the resident for possible placement. The representative was able to converse with R6 in his native language and discovered he enjoyed weaving baskets.

When requested documentation related to activities provided for R6, the following was noted: (11/2/15 thru 12/12/15) -R6 received only two 1:1's with staff (11/4 & 11/7). The week of 11/16-11/22/15 R6 received 1:1 activity. Although the AD indicated she had provided 1:1 in-room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21435	Continued From page 54	21435		

Continued From page 54

programming with R6, she was unable to provide documentation to demonstrate this had been implemented nor could she recall when this had occurred. AD stated she offered an Ipod with headphones for R6 to listen to music in his own language. The AD then provided documentation indicating the Ipod was offered 5 times in November and 4 times in December 2015. When questioned about the preferred activities (wrestling and war movies) documented on R6's care plan, she indicated being unaware of these preferences. When the current activity sheets were reviewed to substantiate the activities each resident had attended, there was nothing highlighted and/or documented indicating that R6 had been involved in activities during the days of observations.

When further interviewed on 12/31/15, at 10:21 a.m. the AD was unable to provide documentation of activities offered in 11/15 and provided 5 days of activity sheets for 10/15, and provided only ten days of documentation for 12/15. The sheets indicated R6 attended exercise on 12/21/15, and the AD stated he did really well with it. The activity sheets failed to document whether R6 had participated, wandered away and/or refused the activity; the AD confirmed the activity documentation was incomplete.

R23

R23 was admitted on 1/6/15 with diagnoses including: dementia, paranoid personality, mood disorder, and chronic obstructive pulmonary disease (COPD) per the facility diagnosis report. The report further identified R23 was admitted to hospice services on 5/15/15 due to senile degeneration of the brain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ________ B. WING ________	12/31/2015

NAME OF PROVIDER OR SUPPLIER: **VALLEY VIEW MANOR HCC**

STREET ADDRESS, CITY, STATE, ZIP CODE: **200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21435	Continued From page 55	21435		

R23's quarterly Minimum Data Set (MDS) assessment dated 11/6/15, indicated R23 severely impaired cognition, total dependence with locomotion on/off unit, and extensive assistance with bed mobility, transfer, eating, toilet use, and personal hygiene.

R23's significant change MDS assessment dated 5/6/15, indicated activity preferences as: very important to have books, magazines, newspapers to read, very important to do favorite activities, very important to go outside and get fresh air when weather is good, and very important to participate in religious services or practices.

R23's care plan last revised 11/9/15, indicated the resident was dependent on staff for structuring and providing activities that promote wellness stimulation due to cognitive deficits. Interventions included: (1) "1 to 1 bedside/in-room visits and activities if [resident name] is unable to attend out of room events. (2) COGNITIVE: Encourage participation in small groups and/or 1:1 interactions (3) EMOTIONAL: Offer ipod or CD player for individual music enjoyment. (4) ENVIRONMENTAL: Observe [resident name] body language related to over stimulation [Resident name] Recreation/Wellness individual preferences include Bingo, walks, magazines, word search, TV and listening and playing music."

R23 was observed continuously on 12/29/15, from 1:14 p.m. until 3:56 p.m. while lying in bed. A popcorn and move activity was held at 1:30 p.m. in the activity room and the coffee social activity held at 2:30 p.m. in the dining room. Staff did not offer R23 the opportunity to attend either activity.

R23 was again observed continuously on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
21435	Continued From page 56	21435		

12/30/15, from 10:03 a.m. until 10:23 a.m. At 10:03 a.m. R23 was seated in a geri chair in the Cityside dayroom at a table while a church service was currently being held in the activity room.

At 10:21 a.m. R23 remained in the geri-chair with eyes closed. The AD approached another resident seated in w/c located near the Cityside nurses station and asked whether she wanted to attend church. R23 opened her eyes when the AD and the resident left for church but looked away and closed her eyes when they left the area. NA-A then approached R23 at 10:23 a.m. to ask whether she wanted to lay down. R23 nodded "yes". NA-A did not give her the opportunity to attend the church activity before transporting her to her room.

At 11:08 a.m. R23 was observed lying in bed with eyes closed while a Wellness activity was in process. She had not been given the opportunity to attend this activity.

At 3:12 p.m. R23 was again lying in bed with eyes closed. A music activity was being performed in the Cityside dayroom with a resident's family member piano playing. Staff were not observed to offer attendance to the activity to R23.

When interviewed on 12/30/15, at 11:55 a.m. NA-B and NA-A confirmed they had assisted R23 with her morning cares, stating that when offered activities, she often refuses as prefers to lie down. Both NA's confirmed they had not offered R23 attendance at the morning church activity as R23 had been tearful that morning when receiving care and they felt the resident would rather lie down. NA-B further stated the resident liked to color when first admitted and will attend

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21435	Continued From page 57	21435		

church though at times will become disruptive during the service.

When interviewed on 12/30/15, at 1:40 p.m. the AD stated R23's activities included hair care, a daily Sunshine group (sensory group) which is implemented twice daily Monday-Friday and once on Saturdays). AD stated the resident usually does fine while attending church service but sometimes needed to be removed from the service as would get agitated. AD confirmed she would still expect R23 be offered the opportunity to participate in attending church. AD attempted to located documentation of activities attended and 1:1's provided for R23. The 1:1 activity sheets indicated R23 was to have 1:1's three times/weekly. AD provided 1:1 documentation from 11/2/15 - 12/5/15 (minus the week of 11/16/15 - 11/22/15); R23 was provided a 1:1 on 7 occasions during this period (11/5/15, 11/7/15, 11/12/15, 11/13/15, 11/27/15, 12/4/15, 12/7/15). AD confirmed the 1:1 charting was inadequate and did not identify the activity, time and/or response. Staff would not be able to evaluate effectiveness of planned interventions.

When interviewed on 12/31/15, at 10:21 a.m. the AD provided 10 days of December 2015 activity sheets for R23. The sheets indicated R23 was offered activities on 5 of the 10 days. AD was unable to provide documentation of activities offered in November 2015 and provided 5 days of activity sheets for October 2015. The activity sheets did not include evidence if the resident had participated or refused the activity; AD confirmed the charting of activities was incomplete.

SUGGESTED METHOD OF CORRECTION: The activity director could train all staff to ensure each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
21435	Continued From page 58 resident's assessed activity preferences are honored, and then audit to ensure this is occurring. Results of these audits could then be reviewed at the quality assurance meetings. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21435		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the safe practice of self-administration for 1 of 2 residents (R6) who were observed self- administering a nebulizer treatment. Findings include: R6's physician orders dated 12/8/15, included Ipratropium-Albuterol solution 0.5-2.5 (3) milligrams/3 milliliters, 1 vial inhale orally three times a day for shortness of breath, every 6 hours while awake. R6's annual Minimum Data Set (MDS) dated 10/9/15, indicated R6 had severe cognitive impairment. Review of R6's care plan dated 10/12/15 included	21565	Completion Date: 2-8-16	2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21565	Continued From page 59	21565		

a risk for alteration in respiratory status related to (r/t) diagnoses of emphysema/COPD (chronic obstructive pulmonary disease) with recurrent acute episode. History of (h/o) pneumonia, and h/o bronchospasms (sudden constriction of the muscles in the walls of the bronchioles causing difficulty breathing). The care plan further identified a behavior problem r/t dementia which included routinely refusing neb (nebulizer) treatments.

Further review of the medical record did not include evidence of an assessment related to R6's ability to self-administer medications.

On 12/29/15, at 2:39 p.m. two surveyors observed R6 sitting on the edge of his bed wearing a nebulizer mask with machine running and medication noted in the nebulizer solution receptacle. R6 was alone in the room with no staff present within visualization of the resident.

On 12/29/15, at approximately 2:50 p.m. licensed practical nurse (LPN)-D was observed in R6's room. R6 was sitting on the edge of bed though no longer had the nebulizer mask on nor was the machine running.

When interviewed on 12/31/15, at 9:09 a.m. the director of nursing (DON) confirmed R6 did not have an assessment to self administer medications; the medication nurse was expected to remain with the resident throughout a nebulizer treatment. DON further confirmed C6 had a history of being non-compliant with administration of nebulizer treatments.

The facility policy/procedure titled, Nebulizers included: "10. Monitor the resident throughout the treatment."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
21565	Continued From page 60 SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee ensure the appropriate assessments are conducted to ensure the safe administration of medications. The DON could ensure the staff were educated on the importance of the assessment process. The DON or designee could randomly audit resident records to ensure adequate monitoring and documentation was in place. The DON could could random audits to ensure medication is not left with residents unless deemed safe by the interdisciplinary team. Results of these audits could then be presented at the quarterly QA&A meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure 1 of 5 rooms (Room 109, R6) reviewed with floor or wall damage had bathroom sheet rock that was maintained in good repair. Findings include:	21695	Completion Date: 2-8-16	2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21695	Continued From page 61 During observation of bathroom in room 109 (R6) on 12/31/15, at 8:30 a.m. it was noted to have a hole approximately 15 inches by 4 inches in the sheetrock at the base of the bathroom wall which is adjacent to the tub room. During observation and interview on 12/31/2015, at 8:35 a.m. the maintenance director confirmed the damaged wall in the bathroom of room 109. He stated, "tub has been leaking and this has damaged the resident's wall". He indicated the tub room was adjacent to R6's bathroom. The maintenance director further confirmed a quarter size hole in the wall below the toilet paper dispenser and agreed the areas in the bathroom did not create a homelike environment. The maintenance director could not provide a policy/procedure but indicated staff would fill out a request on the clipboard when there was a problem to be fixed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure resident rooms and bathrooms are in good repair. The administrator or designee could educate all appropriate staff on the policies and procedures for reporting of damage or need for repair. The administrator or designee could develop monitoring systems to ensure ongoing compliance. Results of these monitoring/audits could then be reviewed at the quarterly QA&A meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21975	MN St. Statute 144A.10 Subd. 3 Inspection; Commissioner of Health; Fines	21975		2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, MN 56152**

(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) COMPLETE DATE
21975	Continued From page 62 Subd. 3. Reports; posting. A copy of each correction order and notice of noncompliance, and copies of any documentation supplied to the commissioner of health or the commissioner of human services under section 144A.03 or 144A.05 shall be kept on file at the nursing home and shall be made available for viewing by any person upon request. Except as otherwise provided by this subdivision, a copy of each correction order and notice of noncompliance received by the nursing home after its most recent inspection or re-inspection shall be posted in a conspicuous and readily accessible place in the nursing home. All correction orders and notices of noncompliance issued to a nursing home owned and operated by the state or political subdivision of the state shall be circulated and posted at the first public meeting of the governing body after the order or notice is issued. Confidential information protected by section 13.05 or 13.46, shall not be made available or posted as provided in this subdivision unless it may be made available or posted in a manner authorized by chapter 13. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the most current survey results were posted in an area readily accessible to residents, families and visitors. This had the potential to affect all 40 residents currently residing in the facility. Findings include: During the initial tour of the facility with the	21975	Completion Date: 2-8-16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: ______ B. WING ______	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

(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) COMPLETE DATE
21975	Continued From page 63 director of nursing (DON) on 12/28/15, at 12:00 p.m., observations revealed the current federal and state survey results were not available to residents, families or visitors. The DON indicated the results are usually posted on the bulletin board near the north and south nurses stations, but confirmed they were not. After 15 minutes of looking for the survey results, the DON found them to be in a 3 ring binder placed behind the south nurses station in the residents chart stand. The binder which included the survey results was not visible nor easily accessible to the residents, families or visitors. The DON confirmed this. SUGGESTED METHOD OF CORRECTION: The administrator or designee could re-educate staff to assure the facility survey results are accessible to all residents. The administrator or designee could monitor for continued compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21975		